DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

March 31, 2023

Licensee
Sunrise Of Edina
7128 France Avenue South
Edina, MN 55435

RE: Project Number(s) SL21787015

Dear Licensee:

On March 15, 2023, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the January 13, 2023, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

HHH

Electronically Delivered

February 16, 2023

Licensee
Sunrise Of Edina
7128 France Avenue South
Edina, MN 55435

RE: Project Number(s) SL21787015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on January 13, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

LICENSING ORDERS
The enclosed State Form documents the state licensing orders. The Department of Health 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 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.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00
St - 0 - 1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration - $3,000.00
St - 0 - 2070 - 144g.81 Subd. 4 - Awake Staff Requirement - $3,000.00

The total amount you are assessed is $9,500.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

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

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21787	A. BUILDING: _____ B. WING _____	01/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF EDINA	7128 FRANCE AVENUE SOUTH EDINA, MN 55435

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL21787015-0 On January 9, 2023, through January 13, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 50 active residents: 47 receiving services under the Assisted Living with Dementia Care license. An immediate correction order was identified on January 10, 2023, issued for SL21787015-0, tag identification 2070. On January 11, 2023, the immediacy of correction order 2070 was removed, however, non-compliance remained at a level 3, scope of pattern violation. An immediate correction order was identified on January 11, 2023, issued for SL21787015-0, tag identification 1750.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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0 000	Continued From page 1 On January 12, 2023, the immediacy of correction order 1750 was removed, however, non-compliance remained at a level 3, scope of isolated violation. An immediate correction order was identified during the supervisory review process on February 7, 2023, issued for SL21787015-0, tag identification 1290. On February 8, 2023, the immediacy of correction order 1290 was removed, however, non-compliance reamained at a level 3, scope of widespread violation.	0 000		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter;	0 250		

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0 250	Continued From page 2 (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records	0 250		

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0 250	Continued From page 3 reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on January 9, 2023, at approximately 10:34 a.m., licensed assisted living director (LALD)-C and registered nurse (RN)-D stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat.	0 250		

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0 250	Continued From page 4 sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and	0 250		

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0 250	Continued From page 5 Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page seven was electronically signed by owner (O)-K on May 27, 2022. The licensee had an assisted living with dementia license issued on August 1, 2022, with an expiration date of June 30, 2023. The licensee failed to ensure the following	0 250		

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0 250	Continued From page 6 policies and procedures were developed and/or implemented: - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - infection control practices; - reminders for treatments; - medication and treatment management; and - supervision of unlicensed personnel performing delegated tasks. On January 11, 2023, at 4:30 p.m., LALD-C confirmed the licensee provided assisted living with dementia care but failed to implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued 0470, 0480, 0510, 0650, 0680, 0700, 0730, 0780, 0800, 0810, 1060, 1170, 1190, 1290, 1420, 1470, 1500, 1620, 1640, 1750, 1760, 1880, 1890, 1910, 2070, 2110, 2260, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;	0 470		

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0 470	Continued From page 7 (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a daily work schedule posted in a central location accessible to staff, residents, volunteers, and the public as required and failed to develop and implement a written staffing plan that included an evaluation completed by a registered nurse at least twice a year. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 470		

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0 470	Continued From page 8 cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's census was 50 residents, 47 of whom received services under the assisted living with dementia care license. The licensee failed to have the daily work schedule posted in a central location accessible to staff, residents, volunteers, and the public. During the entrance conference on January 9, 2023, at approximately 10:32 a.m., the evaluator requested a staffing plan. Licensed assisted living director (LALD)-C, stated the staffing plan posted was generic and was updated depending on census, and was not updated with daily updates or call ins. On January 9, 2023, from 11:26 a.m. to 11:56 a.m., during a facility tour, the evaluators observed the posted staffing plans to be generic and not up to date. The facility's layout consisted of three floors. First floor held one assisted living apartment and one memory care unit (MC-1). Second floor held 34 assisted living apartments, and the third floor held 11 assisted living apartments and one memory care unit (MC-2). On January 10, 2023, at 8:59 a.m., LALD-C stated the licensee used a matrix for determining staffing levels that was created by an electronic staffing system and the licensee did not have a written staffing plan which included an evaluation, completed by a registered nurse at least twice a year.	0 470		

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0 470	Continued From page 9 The licensee's staffing-direct care policy dated September 3, 2021, read, "It is the policy of the community to have a staffing plan that provides an adequate number of qualified team members scheduled to meet operational requirements and the needs of the residents. The daily work schedule will be posted a. After redacting direct-care team members' resident assignments b. At the beginning of each work shift c. In a central location in each building of a community or campus, accessible to team members, residents, volunteers, and the public." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and	0 480		

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0 480	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports, dated January 9, 2023. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as	0 510		

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0 510	Continued From page 11	0 510		

applicable, for infection prevention and control in assisted living facilities.
(c) The facility must maintain written evidence of compliance with this subdivision.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to maintain an effective infection control program to comply with acceptable health care, medical, and nursing standards for infection control for three of three residents (R4, R5, R9).

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:

CARES
On January 10, 2023, at 6:17 a.m., the evaluator observed unlicensed personnel (ULP)-H apply gloves, assist R5 with ambulation to the bathroom, and remove R5's incontinent brief soiled with urine. Without removing soiled gloves and hand hygiene, ULP-H removed R5's transfer belt, socks, and pants, washed and dried R5's breasts and groin, applied nystatin powder to R5's groin and deodorant to arms, dressed R5's upper body and placed items for lower body, and provided peri (perineal) care. Without removing soiled gloves and hand hygiene, ULP-H completed dressing R5 by raising all clothing items on lower extremities, transferred R5 to the

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0 510	Continued From page 12	0 510		

wheelchair and removed gloves. Without hand hygiene ULP-H applied new gloves, assisted with oral care, and removed gloves. Without hand hygiene ULP-H put on wheelchair pedals, opened curtains, placed R5's glasses, escorted R5 to the dining room, and there, performed hand hygiene.

On January 10, 2023, at 6:53 a.m., the evaluator observed ULP-H apply gloves assist R9 with incontinent brief removal. Without removing soiled gloves and hand hygiene, ULP-H removed shirt, washed and dried R9's face, back, chest, removed shoes and socks, washed and dried lower legs, groin, and provided peri care. Without removing solid gloves and hand hygiene, ULP-H applied R9's shirt, socks, pants, incontinent brief, stood R9 up, and washed and dried R9's buttock region. Without removing soiled gloves and hand hygiene, ULP-H completed dressing R9 by raising all clothing items on the lower extremities, transferred R9 to the wheelchair, removed gloves and then performed hand hygiene.

On January 10, 2023, at 7:21 a.m., ULP-H stated they were trained on resident cares by shadowing other ULP's. In addition, ULP-H stated they were trained to wash hands every time they worked with a resident for 20 seconds, and to wear gloves before touching resident or when completing peri care.

On January 10, 2023, at 9:13 a.m., registered nurse (RN)-D stated staff where trained for infection control at Sunrise University during orientation, and competencies were completed on hand hygiene. RN-D stated staff were trained to wash hands when working with a resident with Clostridium difficile infection (C-Diff) and between residents. In addition, RN-D stated after glove removal staff were trained to use sanitizer

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0 510	Continued From page 13 between glove changes up to 5 times or wash hands if visibly soiled, and when assisting with toileting a resident they should remove gloves after incontinent brief removal and after cleaning of perineal area. The Centers for Disease Control and Prevention (CDC) Hand Hygiene in Health Care Settings Healthcare Providers dated January 8, 2021, directed health care workers to wash their hands immediately before touching a patient [resident], after touching a patient or patient's immediate environment, after glove removal, and when hands were visibly soiled. DROPPED MEDICATION On January 10, 2023, at 6:36 a.m., during medication administration, the evaluator observed ULP-B drop one of R4's medications on the medication cart, pick up the medication with ungloved hands, put medication back into the medication cup, and administer all five medications in the cup to R4. On January 10, 2023, at 9:13 a.m., RN-A stated if medication was dropped, the staff should dispose of dropped medication, administer a new dose of medication, and request from pharmacy a new medication to replace the medication that was dropped. MEDICATION PASS On January 10, 2023, at 6:47 a.m., during medication administration, the evaluator observed ULP-B attach a needle to R4's Lantus Solostar insulin pen without disinfecting the pen tip (rubber seal). On January 10, 2023, at 9:16 a.m., RN-A stated the staff were trained to disinfect the insulin pens	0 510		

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0 510	Continued From page 14 prior to attaching the needles. The manufacturer's guidelines for Lantus Solostar insulin pen, dated March 2020 instruct the pen tip (rubber seal) to be disinfected by wiping with an alcohol swab prior to attaching the needle. The licensee's Infection Prevention and Control Program policy dated June 14, 2021, indicated the licensee followed the CDC and Association for Professionals in Infection Control and Epidemiology (APIC) to support the licensee's infection control program. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days .	0 510		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, 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	0 650		

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0 650	Continued From page 15 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. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained the required content for two of two employees (unlicensed personnel (ULP)-B, and ULP-E) with records reviewed. 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 ULP-B began employment with the licensee, under the comprehensive license and started providing assisted living services August 1, 2021.	0 650		

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0 650	Continued From page 16 ULP-B's employee record lacked the following documentation of required competency training completed by a registered nurse (RN): -care and use of hearing aids; -reading and recording temperature, pulse, and respirations of the resident; -range of motioning and positioning; -administering medications or treatments as required; -preparing medications and all medication route procedures; and -blood glucose. On January 11, 2023, at 9:45 a.m., ULP-B stated they had been trained in a medication class through zoom with a nurse and had been trained on insulin and blood glucose monitoring prior to passing medications independently. ULP-E ULP-E began employment with the licensee, under the comprehensive license and started providing assisted living services August 1, 2021. ULP-E's employee record lacked the following documentation of required competency training completed by a RN: -administering medications or treatments as required; -preparing medications and all medication route procedures; and -blood glucose. On January 10, 2023, at 7:34 a.m., ULP-E stated they were trained for medication administration by corporate and completed a medication competency at the facility with an RN. On January 11, 2023, at 1:09 p.m., business	0 650		

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0 650	Continued From page 17 office coordinator (BOC)-J stated they were unaware they needed competency documentation on hearing aids, and they did not have documentation of competency on vital signs for ULP-B. BOC-J stated, "We are having a hard time locating her [ULP-E] competencies on medications, blood glucose, and insulin." On January 11, 2023, at 1:10 p.m., licensed assisted living director (LALD)-C stated they are one of four campuses that are rotated for hosting trainings each week and "when they [indicating unlicensed personnel] are trained at other campuses we don't always get their paperwork back. It is unfortunate." The licensee's Supervision of Licensed & Unlicensed Team Members, dated August 19, 2021, indicates, "After completing the Sunrise Medication Administration course training and competency requirements, the RCD/RN or appropriate LPH [licensed health professional] will complete the initial supervisory medication pass observations with the Medication Care Manager (MCM) within 30 days, then once monthly for three months, thereafter once quarterly, and as needed based on performance." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements:	0 680		

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0 680	Continued From page 18 (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 tenant 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 disaster plan with all required content and failed to post an emergency plan prominently. This had the potential to affect all residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 680		

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0 680	Continued From page 19 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During tour upon entrance to the facility on January 29, 2023, at approximately 11:00 a.m., the evaluator observed no signage posted or information regarding the licensee's emergency plan. During the entrance conference on January 29, 2023, at approximately 10:45 a.m., the evaluator requested to view the licensee's emergency preparedness plan. The licensee's undated emergency preparedness plan (EPP) included generic documents not specific to the licensee's facility and lacked the following required content: -current, all-hazards approach facility assessment; -description of the population served by licensee; -process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; -subsistence needs for staff and residents during emergency situation; -procedure for tracking staff and residents; -development of all policies/procedures, based on assessment; and additional policies for: -potential evacuation; -sheltering in place; -handling medical documents; -handling and use of volunteers; -arrangement with other faculties (including sister facilities); -development of a communication plan, including primary and alternate means for communication; -methods for sharing information;	0 680		

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0 680	Continued From page 20 -EP training and testing program; -EP training program for staff (including documentation of training provided); -annual EP testing requirements. On January 11, 2023, at approximately 10:50 a.m., licensed assisted living director (LALD)-C stated the emergency preparedness binder was located in their locked office which indicated if an emergency occurred when LALD-C was not present in the facility, staff would not have access to the EPP. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident's personal health and medical information was kept private for eight of 18 memory care residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 700		

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0 700	Continued From page 21	0 700		

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:

There were 18 residents who resided in the licensee's memory care (MC) unit on the third floor. Resident rooms were identified with room number and resident's full names.

On January 10, 2023, at 6:00 a.m., the evaluator observed two residents in the third- floor MC dining room. On the wall there was a white board titled Resident Food Restrictions, which identified the following:
- [resident initials] 321 - mechanical soft food;
- [resident initials] 317 - mechanical soft food/no red meat;
- [resident initials] 304 - no sugar/diabetic;
- [resident initials] 305 - mechanical soft;
- [resident initials] 306 - thickened liquids;
- [resident initials] 311 - no dairy no coffee;
- 317, 306 need assistance eating;

On January 10, 2023, at 6:04 a.m., the evaluator observed the staff office unattended with the door propped open. In the window visible from the common area, was a handwritten note that read, "[R4's] appointment Tuesday January 10th. Have ready by 1:00 p.m.", and a sign that read, "please use only Hoyer lift with room 306 even if wife insists on using easy stand. It is in his care plan! Hoyer is by his room. Thanks."

On January 10, 2023, at 9:18 a.m., registered nurse (RN)-D stated the resident's information

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0 700	Continued From page 22 should be kept private and information kept in the care manager's station with the door closed to keep private information secured. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		
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; (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	0 730		

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0 730	Continued From page 23 professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary for one of three discharged residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 admitted to the licensee for services on May	0 730		

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0 730	Continued From page 24 23, 2022, and discharged to home on December 29, 2022. R1's diagnosis included brief hypertension. R1's record lacked a discharge summary. On January 9, 2023, at 2;49 p.m., registered nurse (RN)-D stated the licensee created a move out progress note to complete when a resident discharged from the licensee that included a discharge summary. RN-D stated R1's record lacked a discharge summary, and it was not completed in error. The licensee's undated The Discharge Process and your Readmission Rates procedure indicated the charge nurse would complete a transfer /discharge summary assessment. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;	0 780		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF EDINA	7128 FRANCE AVENUE SOUTH EDINA, MN 55435

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0 780	Continued From page 25 (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; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms immediately outside sleeping areas in the two-bedroom apartments and failed to ensure smoke alarms are interconnected so that the actuation of one alarm causes all alarms in the dwelling to actuate as required. 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, 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: On January 12, 2023, between 1:00 p.m. and 3:00 p.m., survey staff toured the facility with the	0 780		

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0 780	Continued From page 26 maintenance coordinator (MC)-L. During the facility tour, survey staff observed there was no smoke alarm in the common area outside the bedrooms in apartment 301. MC-L stated it would be the same for every two-bedroom apartment in the building. MC-L verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. 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	0 800		

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0 800	Continued From page 27 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On January 12, 2023, from approximately 1:00 p.m. to 3:00 p.m., survey staff toured the facility with the maintenance coordinator (MC)-L. During the facility tour, survey staff observed the following: 1. The electrical closets next to apartments 334, 309, 321, 234,121 had no fire sealant at penetrations in the ceilings. The electrical closet next to apartment 309 was also missing an escutcheon on the sprinkler head and a cover plate on the outlet. The electrical closet next to apartment 234 had large holes cut in the ceiling and wall. 2. The third-floor and first-floor laundry rooms had sprinkler heads that were covered in lint. MC-L verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:	0 810		

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0 810	Continued From page 28 (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain fire safety and evacuation plans and failed to provide required training to residents and employees for fire safety and evacuation. This had the potential to affect all current residents, staff, and visitors to the facility.	0 810		

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0 810	Continued From page 29 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: During interview on January 12, 2023, at 3:00 p.m., Business Office Coordinator (BOC)-J stated they do training upon hire and once per year after that. She also stated they do three fire drills per month. Review of the Emergency Preparedness Plan, Section 5 - Fire policy showed the following: 1. No evacuation plan or documentation on specific procedures for the residents including procedures for their movements, and relocation during a fire or similar emergency. No written instructions for addressing any unique situation during an evacuation, especially for residents who need assistance during an evacuation. The policy only included shelter-in-place procedures and did not include information on a full, emergency evacuation. 2. Training records indicated staff are trained upon hire and once per year thereafter. The statute requires training for staff upon hire and twice per year thereafter. 3. No schedule or records on the training of residents who are capable of assisting in their evacuation; on proper actions to take in the event	0 810		

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0 810	Continued From page 30 of a fire or emergency for their safety including movement, evacuation, or relocation. 4. The Fire Safety and Evacuation Plans were not readily available in the facility. Staff struggled to find the most current version of the plans along with the training records. The survey staff reviewed two outdated versions of the plans before the most current version was found and submitted for review. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the	01060		

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01060	Continued From page 31 resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation for one of one resident (R3) with records reviewed. 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:	01060		

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01060	Continued From page 32 R3 admitted for services on September 30, 2022. R3's unsigned service plan dated September 30, 2022, indicated R3 received services for medication management, activities, meals, mobility, bathing, and laundry. R3's Progress Notes dated September 30, 2022, through October 13, 2022, indicated the licensee sent R3 to the Fairview Southdale hospital on October 1, 2022, for elevated blood glucose level and R3 returned to licensee on October 8, 2022. R3's record lacked a written notice delivered to the resident or designated representative that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for OOLTC; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R3's record lacked notification to OOLTC when R3 did not return to the facility within four days. On January 10, 2023, at 12:38 a.m., registered nurse (RN)-D verified R3's record lacked a written emergency relocation notice, and stated the	01060		

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01060	Continued From page 33 licensee did not update the OOLTC. RN-D and licensed assisted living director (LALD)-C stated they were unaware of the requirement and have not issued notices or contacted the OOLTC on any resident who had a hospitalization longer than four days. The licensee's undated The Discharge Process and your Readmission Rates indicated the licensee would send a bed hold agreement and a facility notice of transfer with resident when they were transferred out of the facility. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01060		
01170 SS=F	144G.56 Subd. 3 Notice required (a) A facility must provide at least 30 calendar days' advance written notice to the resident and the resident's legal and designated representative of a facility-initiated transfer. The notice must include: (1) the effective date of the proposed transfer; (2) the proposed transfer location; (3) a statement that the resident may refuse the proposed transfer, and may discuss any consequences of a refusal with staff of the facility; (4) the name and contact information of a person employed by the facility with whom the resident may discuss the notice of transfer; and (5) contact information for the Office of Ombudsman for Long-Term Care. (b) Notwithstanding paragraph (a), a facility may conduct a facility-initiated transfer of a resident with less than 30 days' written notice if the transfer is necessary due to:	01170		

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01170	Continued From page 34 (1) conditions that render the resident's room or private living unit uninhabitable; (2) the resident's urgent medical needs; or (3) a risk to the health or safety of another resident of the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to provide a 30-day calendar day advance written notice to the resident and/or the resident's legal/designated representative, prior to initiating the transfer for three of three residents (R12, R13, R14). 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 January 9, 2023, at 11:03 a.m., during the entrance conference, licensed assisted living director (LALD)-C stated the licensee was working on transitioning residents from the first-floor memory care unit to the third-floor memory care unit due to staffing concerns. In addition, LALD-C stated three residents remained on the first-floor and all other residents who previously lived on the first-floor were relocated to the third-floor. R12, R13, and R14 moved from first floor to third-floor on January 10, 2023.	01170		

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01170	Continued From page 35 The facility lacked documentation showing a 30-day written notification was provided to residents and the residents' legal and designated representative as required that contained the following: - (a) facility must provide at least 30 calendar days advance written notice to the resident and the resident's legal and designated representative of a facility-initiated transfer; - the effective date of the proposed transfer; - the proposed transfer location; - a statement that the resident may refuse the proposed transfer, and may discuss any consequences of a refusal with staff of the facility; - the name and contact information of a person employed by the facility with whom the resident may discuss the notice of transfer; and - contact information for OOLTC. On January 11, 2023, at 12:21 p.m., LALD-C stated they did not have a written notice of relocation however, the licensee talked to the resident's families over the past month, and everyone was in agreement to move. The evaluator inquired if the licensee had documented the conversations held with families for all residents who moved from the first-floor to the third-floor. LALD-C provided the evaluator letters dated January 10, 2023, which LALD-C stated they emailed to the resident's families on that date. The letter contained a statement confirming the resident's move and indicated the licensee discussed potential moves with residents or resident's family members. The letters read, "I really appreciate the opportunity to have worked with you for the last couple months over this matter." No further information was provided.	01170		

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01170	Continued From page 36 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01170		
01190 SS=F	144G.56 Subd. 5 Changes in facility operations (a) In situations where there is a curtailment, reduction, or capital improvement within a facility necessitating transfers, the facility must: (1) minimize the number of transfers it initiates to complete the project or change in operations; (2) consider individual resident needs and preferences; (3) provide reasonable accommodations for individual resident requests regarding the transfers; and (4) in advance of any notice to any residents, legal representatives, or designated representatives, provide notice to the Office of Ombudsman for Long-Term Care and, when appropriate, the Office of Ombudsman for Mental Health and Developmental Disabilities of the curtailment, reduction, or capital improvement and the corresponding needed transfers. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide notice to the Office of Ombudsman for Long-Term Care (OOLTC) or the Office of the Ombudsman for Mental Health and Developmental Disabilities (OMHDD) of corresponding transfers needed for curtailment (reducing or restricting), prior to notifying residents or residents representative for three of three residents (R12, R13, R14). 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	01190		

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01190	Continued From page 37 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 January 9, 2023, at 11:03 a.m., during the entrance conference, licensed assisted living director (LALD)-C stated the licensee was working on transitioning residents from the first floor memory care unit to the third floor memory care unit due to staffing concerns. In addition, LALD-C stated three residents remained on the first floor and all other residents who previously lived on the first floor were relocated to the third floor. The licensee moved R12, R13, and R14 from first floor to third floor on January 10, 2023. R12, R13, and R14's record lacked evidence that OOLTC or OMHDD had been notified of the transfers. On January 11, 2023, at 12:21 p.m., LALD-C stated the licensee did not contact OOLTC or OMHDD and they were unaware of the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01190		
01290 SS=I	144G.60 Subdivision 1 Background studies required	01290		

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01290	Continued From page 38 (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 an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for two of three employees (unlicensed personnel (ULP)-B and ULP-E). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B began employment with the licensee, under the former comprehensive license and	01290	On February 8, 2023, the immediacy of correction order 1290 was removed, however, non-compliance reamained at a level 3, scope of widespread violation.	

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01290	Continued From page 39 started providing assisted living services August 1, 2021. On January 11, 2023, at 6:36 a.m., the evaluator observed ULP-B administer oral medications to R4. ULP-B's employee record contained a background study dated October 23, 2018, affiliated to licensee's former health facility identification number (HFID) 20814. ULP-B's record lacked evidence the licensee submitted a background study for ULP-B under the current assisted living with dementia care license and affiliated to the current HFID number. ULP-E ULP-E began employment with the licensee, under the former comprehensive license and started providing assisted living services August 1, 2021. On January 11, 2023, between 7:10 a.m. and 7:34 a.m., the evaluator observed ULP-E administer oral medications to R6, R11, and R12. ULP-E's employee record contained a background study dated July 15, 2016, affiliated to licensee's former HFID 20814. ULP-E's record lacked evidence the licensee submitted a background study for ULP-E under the current assisted living with dementia care license and affiliated to the current HFID number. On January 11, 2023, at 12:21 p.m., business office coordinator (BOC)-J acknowledged ULP-B and ULP-E's, employee records lacked a background study affiliated to the current license and stated, "we did not run new background checks on our employees when we got the new	01290		

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01290	Continued From page 40 HFID number." On February 7, 2023, at 8:40 a.m., the evaluator observed Minnesota Department of Human Services NETStudy2.0 (web-based system used to submit background study requests) which indicated ULP-E had two completed background studies affiliated with HFIDs not associated with the licensee, however, lacked a background study affiliated with licensee's HFID 21787. On February 7, 2023, at 8:46 a.m., the evaluator observed Minnesota Department of Human Services NETStudy2.0 which indicated ULP-B had two completed background studies affiliated with HFIDs not associated with the licensee, however, lacked a background study affiliated with licensee's HFID 21787. On February 7, 2023, at 11:23 a.m., licensed assisted living director (LALD)-C stated the licensee holds an assisted living with dementia care licensure, and they believed the licensee's comprehensive license closed when the licensee received the new license for assisted living with dementia care. The licensee's Employment Verifications and Background checks dated May 31, 2019, indicated background checks are conducted on all applicants who have been offered employment. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	01290		
01420 SS=D	144G.62 Subd. 2 Delegation of assisted living services	01420		

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01420	Continued From page 41 (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If an unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on interview, and record review, licensee failed to provide delegated training by a registered nurse (RN) to unlicensed personal (ULP) for the use of an external female catheter for one of one resident (R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R7 was admitted to the licensee June 10, 2020, and started receiving assisted living services August 1, 2021.	01420		

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01420	Continued From page 42 R7's diagnoses included chronic pain syndrome, age related osteoporosis, anemia, major depressive disorder, urinary incontinence, peripheral vascular disease, and hyperlipidemia. R7's unsigned service plan identified she received services including medication management, assist with a PureWick external urinary catheter, meals, housekeeping, and laundry. R7's December 28, 2022, comprehensive assessment identified R7 had urinary incontinence and used incontinent products pads and briefs. The assessment did not identify R7's use of a PureWick external urinary catheter system or that the staff were to assist R7 with the use of the catheter. On January 11, 2023, at 11:18 a.m., ULP-I stated R7's external urinary catheter was placed by staff at bedtime. In the morning, ULP-I stated they remove the catheter and dispose of it, and then they empty and rinse the urine collection canister. R7's task administration record for the month of January 2023, did not identify a service to apply or remove the external urinary catheter or to empty and clean the canister. On January 11, 2023, at 11:22 a.m., registered nurse (RN)-D stated there should have been training completed by the RN when the PureWick external urinary catheter was initiated, and new staff should be trained by an RN during general orientation. RN-D further stated on January 11, 2023, at 12:50 p.m., staff had not been trained for this task by a nurse and there was no documentation of staff training.	01420		

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01420	Continued From page 43 On January 11, 2023, at 12:50 p.m., ULP-L stated the services provided were not on the service schedule (task administration record) and it would need to be added. ULP-L stated he or another lead ULP trained the other ULP's on the PureWick external catheter and how to place, remove, and clean the canister. ULP-L further stated there was no documentation of staff training. On January 11, 2023, at 2:26 p.m., R7 stated she had the PureWick external urinary catheter system for about a year. She requested a family member purchase it for her after seeing an advertisement. R7 stated she used it overnight, the facility staff place it at bedtime, remove it in the morning, and take care of emptying the canister. R7 stated sometimes if the staff do not place it correctly it hurts but she is able to let them know right away, and they fix it. Further, R7 stated, if it isn't placed correctly at night, it will not work well and does not drain the urine away like it should, so she will wake up wet from the urinary incontinence. The PureWick Female External Catheter dated 2020, identified the following steps for use: Set-up "1. Plug power cord into device outlet and into the A/C power outlet. Note: Make sure the power switch is turned off. 2. Place collection canister in the base and press down firmly on the lid of the device making sure lid is sealed. 3. Optional: Slip privacy cover onto the canister prior to placing canister into base. 4. Attach pump tubing (short tube) to the PureWick (Trademark) Urine Collection System connector	01420		

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01420	Continued From page 44 port and the connector port on the collection canister lid. 5. Attach the elbow connector to the collector tubing (long tube) and connect elbow connector to the connector port on collection canister lid. 6. Connect other end of collector tubing (long tube) to a PureWick (Trademark) External Catheter." Placement "7. A. Perform perineal care and assess skin integrity. B. Separate legs, gluteus muscles and labia. Palpate by using pubic bone as anatomical marker. 8. A. With soft gauze side facing patient, align distal end at gluteal cleft. B. Gently tuck soft gauze side between separated gluteus and labia." Removal and maintenance "9. Fully separate the legs, gluteus, and labia. A. To avoid potential skin injury upon removal, gently pull the PureWick (Trademark) Female External Catheter directly outward. B. Ensure suction is maintained to draw urine out of the collector tubing and into the collection canister before removing the PureWick (Trademark) Female External Catheter. 10. Replace at least every 8-12 hours or if soiled with feces or blood. Assess skin for compromise and perform perineal care prior to placement of a new PureWick (Trademark) Female External Catheter." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01420		

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01470	Continued From page 45	01470		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any	01470		

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01470	Continued From page 46 training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for three of three employees (registered nurse (RN)-A, unlicensed personnel (ULP)-B, ULP-E) with records reviewed. 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:	01470		

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01470	Continued From page 47 RN-A RN-A began employment with the licensee November 30, 2022, to provide assisted living services. RN-A employee records lacked evidence of orientation to assisted living regulations (144G.63, Sub. 2) effective August 1, 2021, for the following: - an overview of this assisted living statutes; - a review of the types of assisted living services the employee will be providing and the facility's category of licensure; and - the assisted living bill of rights. ULP-B ULP-B began employment with the licensee, under the comprehensive license and started providing assisted living services August 1, 2021. ULP-B's document titled Onboarding Ignite Your Potential completed October 29, 2018, to November 16, 2018, included home care orientation and homecare bill of rights. The evaluator reviewed additional training records which lacked evidence of orientation to assisted living regulations (144G.63, Sub. 2) effective August 1, 2021, for the following: -an overview of this assisted living statutes; and -the assisted living bill of rights. ULP-E ULP-E began employment with the licensee, under the comprehensive license and started providing assisted living services August 1, 2021. ULP-E's document titled Minnesota Comprehensive home Care License for Assisted Living- Orientation Checklist and Requirements completed July 26, 2016, through August 1, 2016,	01470		

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01470	Continued From page 48 included home care bill of rights and overview of home care licensure. ULP-E's employee record lacked documented evidence of orientation to assisted living regulations (144G.63, Sub. 2) effective August 1, 2021, for the following: - an overview of this assisted living statutes; and - the assisted living bill of rights. On January 11, 2023, at 1:09 p.m., business office coordinator (BOC)-J verified ULP-B and ULP-E's employee records lacked the above training for orientation to assisted living regulations (144G.63, Sub. 2) effective August 1, 2021, as required, and verified all employees hired before August 1, 2021, would lack the same training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control	01500		

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01500	Continued From page 49 standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual	01500		

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01500	Continued From page 50 and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for two of two employees (unlicensed personnel (ULP)-B and 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 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: ULP-B ULP-B began employment with the licensee, under the comprehensive license and started providing assisted living services August 1, 2021. ULP-E ULP-E began employment with the licensee, under the comprehensive license and started providing assisted living services August 1, 2021. ULP-B and ULP-E's record lacked evidence annual training had been completed as required in the following areas: -review of the assisted living bill of rights (BOR) and staff responsibilities related to ensuring the exercise and protection of those rights.	01500		

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01500	Continued From page 51 On January 9, 2023, at 2:54 p.m., business office manager (BOC)-J stated the licensee had provided all staff the home care BOR however, they would work on updating training to the assisted living BOR. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.	01620		

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01620	Continued From page 52 This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure licensed staff conducted resident monitoring and review as needed based on changes with resident needs for one of four residents (R6) and failed to ensure the registered nurse conducted ongoing resident assessment and reassessment, not to exceed 90 calendar days from the last date of the assessment for three of four residents (R4, R6, and R7). 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: CHANGE OF NEEDS R6 was admitted to the licensee June 30, 2021, and started receiving assisted living services August 1, 2021. R6's diagnoses included spinal stenosis, benign prostatic hyperplasia without lower urinary tract symptoms, calculus of kidneys, and anxiety. R6's service plan signed January 10, 2023, indicated R6 received assistance with housekeeping, laundry, bathing, meals, perineal care, dressing, mobility, transfers, medication management, ostomy and foley care including measuring output and draining of appliances. R6's task records dated January 1, 2023, through	01620		

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01620	Continued From page 53 January 31, 2023, indicated staff emptied and cleaned nephrostomy (a thin plastic tube that is passed from the back, through the skin and then through the kidney, to the point where it collects urine) bag every shift from January 1, 2023, to January 10, 2023. On January 11, 2023, at 11:14 a.m., the evaluator inquired if they could observe R6's nephrostomy care. Unlicensed personnel (ULP)-I stated R6's nephrostomy tube was removed a couple months ago. R6's 3.0 SEHA - V10 dated December 27, 2022, indicated R6 had a catheter and staff were to assist with catheter care which included draining of catheter bag two to four times per shift and as needed. R6's record lacked a change of condition assessment based on changes with residents needs. On January 9, 2023, at approximately 10:45, during entrance conference, RN-D stated they completed resident assessments upon admission, 14-days, 90-days, every 6 months, and as needed with change of condition. On January 11, 2023, at 1:10 p.m., registered nurse (RN)-D verified R6's nephrostomy tube was removed. RN-D stated R6's nephrostomy tube was removed "approximately" in November 2022, and tasks for nephrostomy tube should have been removed from the treatment task list and the care plan / service plan. ONGOING ASSESSMENT R4 R4 was admitted to the licensee February 26, 2016, and started receiving assisted living services August 1, 2021.	01620		

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01620	Continued From page 54 R4's Service Plan dated April 22, 2022, indicated services included peri care, bathing assistance, dressing, grooming, oral cares, housekeeping, laundry, blood sugar checks, and medication administration. R4's record included a 90-day nursing assessment dated, November 6, 2021. R4's record included a 90-day nursing assessment dated April 21, 2022, indicating 166 days passed between re-assessments. R4's record included a 90-day nursing assessment dated August 9, 2022, indicating 110 days passed between re-assessments. R6 R6 was admitted to the licensee June 30, 2021, and started receiving assisted living services August 1, 2021. R6's unsigned service plan indicated services included medication management, catheter care, toileting, dressing, grooming, transfers, meals, housekeeping, and laundry. R6's record included a 90-day nursing assessment dated, March 29, 2022. R6's record included a 90-day nursing assessment dated August 10, 2022, indicating 134 days passed between re-assessments. R6's record included a 90-day nursing assessment dated December 27, 2022, indicating 139 days passed between re-assessments. R7	01620		

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01620	Continued From page 55 R7 was admitted to the licensee June 1, 2020, and started receiving assisted living services August 1, 2021. R7's unsigned service plan indicated services included medication management, assist with an external urinary catheter, meals, housekeeping, and laundry. R7's record included a 90-day nursing assessment dated, February 2, 2022. R7's record included a 90-day nursing assessment dated July 28, 2022, indicating 188 days passed between re-assessments. On January 10, 2023, at 12:28 p.m., licensed assisted living director (LALD)-C verified R4's assessment dates and confirmed the 90-day assessments were overdue, as stated above. On January 10, 2023, at 12:28 p.m., registered nurse (RN)-D stated 90-day assessments should not be late and "The earlier dated ones [assessments] are from when I was being trained in, so they probably just didn't get done in time." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.	01640		

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01640	Continued From page 56 (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan was revised based on change of service for one of four residents (R6) and failed to ensure the current service plan included a signature or other authentication by the resident or resident's designated representative to document agreement on the services to be provided for three of four residents (R5, R6, R7). 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	01640		

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01640	Continued From page 57 a large portion or all of the residents). The findings include: REVISED SERVICE PLAN R6 R6 was admitted to the licensee June 30, 2021, and started receiving assisted living services August 1, 2021. R6's diagnoses included spinal stenosis, benign prostatic hyperplasia without lower urinary tract symptoms, calculus of kidneys, and anxiety. R6's unsigned service plan with last review completed date of December 6, 2023, indicated R6 received assistance with medication management, catheter care, transfers, toileting, dressing, grooming, meals, housekeeping, and laundry. R6's service plan signed January 10, 2023, indicated R6 received assistance with housekeeping, laundry, bathing, meals, perineal care, dressing, mobility, transfers, medication management, ostomy and foley care including measuring output and draining of appliances. R6's task records dated January 1, 2023, through January 31, 2023, indicated staff emptied and cleaned nephrostomy (a thin plastic tube that is passed from the back, through the skin and then through the kidney, to the point where it collects urine) bag every shift from January 1, 2023, to January 10, 2023. On January 11, 2023, at 11:14 a.m., unlicensed personnel (ULP)-I stated R6's nephrostomy tube was removed a couple months ago.	01640		

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01640	Continued From page 58 On January 11, 2023, at 1:10 p.m., registered nurse (RN)-D verified R6's nephrostomy tube was removed. RN-D stated R6's nephrostomy tube was removed "approximately" in November 2022, and tasks for nephrostomy tube should have been removed from the treatment task list and the care plan / service plan. AUTHENTICATION R5 R5 was admitted to the licensee for assisted living services on December 9, 2022. R5's diagnoses included dementia, restless leg syndrome, hearing loss, hypertension, and atrial fibrillation. R5's unsigned service plan indicated R5 required assistance with compression stockings, medication management, meals, activities, toileting, oral care, mobility, grooming, dressing, housekeeping, and laundry. R6 R6 was admitted to the licensee June 30, 2021, and started receiving assisted living services August 1, 2021. R6's diagnoses included spinal stenosis, benign prostatic hyperplasia without lower urinary tract symptoms, calculus of kidneys, and anxiety. R6's unsigned service plan indicated R6 received assistance with medication management, catheter care, transfers, toileting, dressing, grooming, meals, housekeeping, and laundry. R7 R7 was admitted to the licensee June 10, 2020, and started receiving assisted living services	01640		

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01640	Continued From page 59 August 1, 2021. R7's diagnoses included chronic pain syndrome, age related osteoporosis, anemia, major depressive disorder, urinary incontinence, peripheral vascular disease, and hyperlipidemia. R7's unsigned service plan indicated she received services including medication management, assist with an external urinary catheter, meals, housekeeping, and laundry. R5, R6, and R7's service plans lacked a signature or other authentication by the resident or resident's designated representative and the licensee to document agreement on the services to be provided. On January 11, 2023, at 9:06 a.m., RN-D verified R5, R6, and R7's records lacked a sign service plan. RN-D stated they placed phone calls to families to update them on services, however, did not document the conversations or obtain a signature for the service plan. On January 11, 2023, at 10:33 a.m., RN-D stated 25 percent of the resident records in the facility lacked a signed service plan. The licensee's Individualized Service Plans (Addendum) dated August 19, 2021, indicated the service plan would be signed and dated when updated and / or revised by the resident and / or resident representative documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		

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01750 SS=G	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prior to delegating the task of medication administration, the registered nurse (RN) trained the unlicensed personnel (ULP) in the proper methods to perform the task or procedure for each resident and verified the ULPs were able to demonstrate the ability to competently follow the procedure for one of two employees, (ULP-G). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at 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:	01750	On January 12, 2023, the immediacy of correction order 1750 was removed, however, non-compliance remained at a level 3, scope of isolated violation.	

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01750	Continued From page 61 ULP-G was hired on March 12, 2020, under the comprehensive license, and began providing services on August 1, 2021, under the assisted living license. On January 10, 2023, at 6:08 a.m., the surveyor observed ULP-G administer oral medication to R14. ULP-G's employee record contained a medication care management training dated November 4, 2021, however lacked a competency evaluation completed by a RN for medication administration. On January 10, 2023, at 6:15 a.m., ULP-G stated they were trained on medication administration by a nurse. The surveyor inquired if a RN observed them to ensure they were competent in the task. ULP-G stated, "No, other unlicensed staff did that part." On January 11, 2023, at 1:09 p.m., licensed assisted living director (LALD)-C stated staff were trained for medication administration at other campuses, and the licensee did not always receive the documentation of training and / or competency evaluations from the other campuses for the employee folder. On January 11, 2023, at 3:47 p.m., business office coordinator (BOC)-J stated they were unable to find the competency evaluations for ULP-G and stated they believed it depended on which resident care director was employed/overseeing the ULP training and competencies at the time as to whether the ULP would have had the medication competency done. The licensee's Team Member Competency and	01750		

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01750	Continued From page 62 Performance Evaluation dated December 12, 2021, indicated training and competency evaluations of a ULP providing assisted living services including medication administration, must be conducted by a RN, or another instructor may provide training in conjunction with the RN. In addition, the licensee would maintain documentation of the team member's competency in the team member's personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	01750		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered according to manufacturer's instructions for one of one resident (R4) with insulin administration and failed to administer	01760		

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01760	Continued From page 63 medications according to provider orders for one of six residents (R9). 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: R9 R9's unsigned service plan indicated R9 received assistance with medication management, oral care, meals, toileting, behavior management, mobility, transfers, grooming, dressing, laundry, and housekeeping. R9's provider order dated August 3, 2022, included Seroquel 12.5 milligrams (mg) in the morning. R9's electronic medication administration record (EMAR) dated January 1, 2023, through January 31, 2023, included Seroquel 12.5 mg one time per day in the morning for anxiety. On January 10, 2023, at 7:50 a.m., the evaluator observed unlicensed personnel (ULP)-B dispense one tablet of Seroquel 25 mg, press yes on the EMAR for Seroquel 12.5 mg, lock the medication cart, and proceed to walk to R9. The evaluator intervened to stop medication administration of Seroquel 25 mg to R9. On January 10, 2023, at 7:55 a.m., the nursing	01760		

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01760	Continued From page 64	01760		

evaluator observed medication cards placed in a specific order of time held together by a metal ring. ULP-B stated they believed they were administering the correct medication because the cards were set in a specific order by another ULP, and they trusted them. In addition, ULP-B stated, "I double guessed myself." ULP-B stated they attended a medication administration class that was taught by a registered nurse (RN).

On January 10, 2023, at 9:24 a.m., RN-D stated staff were trained to check medications three times using the six rights of medication administration.

R4
R4's Service Plan dated April 22, 2022, indicated R4 received medication administration.

R4's provider order dated December 6, 2022, included Lantus Solostar (an injectable medication for diabetes) 20 units daily.

On January 11, 2023, at approximately 6:47 a.m., the evaluator observed ULP-B administer 20 units of insulin to R4's lower left abdomen without priming the insulin pen with two units prior to dialing to the prescribed dose. ULP-B verified they did not prime the insulin pen. ULP-B stated they were trained to eject the 2 units, "but that is wasting the medicine."

On January 11, 2023, at approximately 9:16 a.m., RN-D confirmed the staff should dial the insulin pen to 2 units, eject the 2 units, and then dial the insulin pen to the prescribed dose.

The manufacturer's instruction for the use of Lantus Solostar insulin pen dated March 2020, instructed to prime the pen before each injection,

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01760	Continued From page 65 by dialing a test dose of 2 units, tapping the cartridge holder gently to collect air bubbles at the top, and pushing the dose knob until it stops and returns to 0. The licensee's Medication Management policy dated August 20, 2014, indicated when administration of medications is delegated to unlicensed personnel the RN must instruct them in the proper methods to administer the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
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 ensure all medications were securely locked in substantially constructed compartments and permitted only authorized personnel to have access. This had the potential to affect all 18 residents in the third-floor memory care unit. 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	01880		

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01880	Continued From page 66 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 10, 2023, at 8:04 a.m., during a medication pass, unlicensed personnel (ULP)-B stated powders and creams were stored under the bathroom sink in the resident's room for other ULP's to apply to the resident when they provided cares, and "back up" bottles of powders and creams were kept in the medication cart. ULP-B escorted the evaluator to R5 and R10's rooms where the evaluator observed a clear square bin under each of the sinks that contained nystatin powder for the respective resident. ULP-B stated all powders and creams on the third-floor memory care unit were stored similarly. The surveyor inquired if this was how they were trained to store the medication. ULP-B stated "this is how they do it on this floor. I am a float and do not want to change the routine." On January 10, 2023, at 9:47 a.m., registered nurse (RN)-D stated powders and creams should be stored in the medication cart. The licensee's Storage of Medication policy dated February 19, 2014, indicated prescription medications, over-the-counter medications, and syringes must be kept in an area or container that is locked. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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01890	Continued From page 67	01890		
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 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 for one of three residents (R16) and failed to ensure time sensitive medications were labeled with the date opened for three of three residents (R15, R16, R17) within two of four medication carts (M3 and M4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On January 10, 2023, at approximately 6:57 a.m., the evaluator conducted a review of four locked medication carts on floor two with unlicensed personnel (ULP)-E. The evaluator observed the following in the M3 and M4 medication carts:	01890		

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01890	Continued From page 68	01890		

M3
- R17 had a glargine insulin FlexPen open and in use, kept at room temperature which lacked a date opened or when it would expire.

M4
- R15 had a bottle open and in use of latanoprost (glaucoma) eye drops, labeled with a date open November 28, 2022. It was 43 days since the bottle had been opened; and
- R16 had two opened bottles of Prednisolone 1% (steroid) eye drops. There was a 5 ml bottle and 10 ml bottle within a resealable bag. The prescription label on the bag included an original prescription label that identified a 5ml bottle was dispensed. There was no prescription label identified for the 10ml bottle that was also in the bag.

On January 10, 2023, at approximately 8:07 a.m., registered nurse (RN)-D, confirmed all medications should have original labels, expiration date, be dated after opening with open date and should be stored and discarded per manufacturer directions.

The manufacturer's instructions for Latanoprost ophthalmic solution, dated September 16, 2014, directed to discard the bottle and/or unused contents after 28 days. Latanoprost should not be used after expiration date on the bottle.

The manufacturer's instructions for glargine insulin FlexPens, dated revision June 2022, directed to discard the insulin pen 28 days after it had been opened, stored at room temperature.

The licensee's Storage of Medications policy, dated as reviewed February 19, 2014, indicated "The purpose of this policy and procedure is to

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01890	Continued From page 69 ensure that residents' medication is stored in a safe and secure manner consistent with applicable laws and regulations. A. Storage 1. Prescription medication, over-the-counter medications and syringes must be: a. Kept in an area or container that is locked b. Oral and topical medication must be stored separately c. Stored under proper conditions of sanitation, temperature, moisture and light in accordance with the manufacturer's instruction d. Kept in their original containers and 2. Medications may not be removed from their original labeled containers in advance of the scheduled administration." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name,	01910		

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01910	Continued From page 70 strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include the medication strength, prescription number, and quantity for three of three discharged residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 discharged from the licensee on December 29, 2022. R1's electronic medication administration record (EMAR) dated December 1, 2022, through December 31, 2022, indicated the facility administered the following medications for R1: amlodipine besylate 10 milligrams (mg), fluoxetine 20 mg, folic acid 1000 micrograms (mcg), melatonin 3 mg, metoprolol succinate extended release (ER) 50 mg, potassium 10 milliequivalents (mEq), trazodone 100 mg, vitamin D3 5000 units (U), acetaminophen 1000mg, Mucinex 600 mg, pantoprazole sodium	01910		

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01910	Continued From page 71 40 mg, prochlorperazine maleate 5mg, and buspirone 5mg. R2 R2 discharged from the licensee on December 28, 2022. R2's EMAR dated December 1, 2022, through December 31, 2022, indicated the facility administered the following medications for R2: levothyroxine 88 mcg, lisinopril 10 mg, carvedilol 3.125 mg, and calcium 500 mg. R3 R3 discharged from the licensee on October 29, 2022. R3's EMAR dated October 1, 2022, to October 31, 2022, indicated the facility administered the following medications for R3: amiodarone 200 mg, ascorbic acid 500 mg, atorvastatin calcium 80 mg, vitamin D 1000 U, insulin aspart 100 U / milliliter (ml), metolazone 2.5 mg, multivitamin with minerals, Novolin N 70/ 30 100 U/ ml, Plavix 75 mg, apixaban 2.5 mg, carvedilol 25 mg, gabapentin 200 mg, isosorbide mononitrate 90 mg, nifedipine ER 60 mg, torsemide 60 mg, hydralazine 100 mg, and nitroglycerin 0.4 mg. R1, R2, and R3's record lacked a medication disposition to include the medication's name, strength, prescription number as applicable, and quantity. On January 9, 2023, At 2:49 p.m., registered nurse (RN)-D stated at discharge they provided resident or resident's family member the remaining medications at the facility, and a medication order summary, which included the medication name and strength. RN-D stated the	01910		

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01910	Continued From page 72 licensee did not maintain records of the summary or medications sent with resident or resident's family member at discharge. On January 10, 2023, at 12:22 p.m., RN-D stated they were trained to print out a medication list and review it with the resident or resident family member then write a progress note in the resident record to whom the medications were given to. The evaluator inquired if all discharged records would be missing the medication's name, strength, prescription number as applicable, and quantity. RN-D stated, "yes, I was pretty general with it and just wrote who it was given to in the discharge summary." The licensee's Disposal of Unused Medication dated September 3, 2021, indicated upon disposition the licensed nurse or medication care manager would document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medication was given, date of disposition, and names of team member and other individuals involved in the disposition. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02070 SS=H	144G.81 Subd. 4 Awake staff requirement An assisted living facility with dementia care providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who	02070		

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02070	Continued From page 73 is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12). This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one or more persons were physically present and available 24 hours a day, seven days a week, who were responsible for responding to requests of residents for assistance in one of two secured dementia care (memory care) units. This resulted in an immediate correction order issued on January 10, 2023. 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 January 9, 2023, from 11:26 a.m. to 11:56 a.m., the surveyors toured the facility. The facility's layout consisted of three floors. First floor held one assisted living apartment and one memory care unit (MC-1). Second floor held 34 assisted living apartments, and the third floor held 11 assisted living apartments and one memory care unit (MC-2). The licensee's census was 50 residents, 47 of whom received services under the assisted living with dementia care license.	02070	On January 11, 2023, the immediacy of correction order 2070 was removed, however, non-compliance remained at a level 3, scope of pattern violation.	

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02070	Continued From page 74 On January 10, 2023, during the survey, MC-1 had three residents, and MC-2 had 18 residents. On January 10, 2023, at 6:15 a.m., ULP-G stated she was assigned to work in the assisted living (AL) area of the facility during the previous overnight shift where three of the residents required two staff assist. ULP-G stated during the shift, ULP- F left MC-1 to assist ULP-G in the AL area with the residents who required a two person assist. ULP-G stated this occurred at approximately 4:00 a.m., for "10 minutes", and during that time, MC-1 had no staff present in the unit. ULP-G stated there were two other staff working in the building and both were in MC-2. On January 10, 2023, at 6:22 a.m., ULP-F stated he was working in MC-1 during the previous overnight shift and the three residents living in MC-1 were very independent. ULP-F stated at approximately 2:00 a.m., ULP-G needed assistance in the AL area for a resident who required two person assist. ULP-F stated he also left MC-1 to assist with laundry. ULP-F stated typically somebody would come to relieve him, but there were several call lights on at once, and no other staff were available to relieve him. On January 10, 2023, at 8:07 a.m., registered nurse (RN)- D stated there were four ULP's on duty last night, so there should have been two ULP's in MC-2, one ULP in the AL areas, and one ULP in MC-1. RN-D stated if additional staff was needed in the AL area or MC-1 then one of the ULP's in MC-2 should have assisted, and ULP's are never to leave MC-1 or MC-2 unattended. On January 10, 2023, at 8:59 a.m., licensed assisted living director (LALD)-C stated there	02070		

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02070	Continued From page 75	02070		

were four ULP's scheduled to work last night, two ULP's were to be in the AL area, one ULP should have been in MC-1, and one ULP should have been in MC-2. If additional staff assist was needed in a unit, one of the ULP's in the AL area should assist, and if a ULP needed to leave a memory care unit, they must wait for another staff to relieve them. LALD-C stated ULP-F failed to "follow policy" when he left MC-1 unattended. LALD-C stated the licensee used a matrix for determining staffing levels that was created by an electronic staffing system. The licensee did not have a written staffing plan which included an evaluation, conducted twice a year.

The licensee's Staffing - Direct Care policy dated August 19, 2021, identified "It is the policy of the community to have a staffing plan that provides an adequate number of qualified team members scheduled to meet operational requirements and the needs of the residents." The RN "will develop and implement a staffing plan for determining the community's staffing level that:
a. Includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the community;
b. Ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and
c. Ensures that the community can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting team members or residents in the community."
"It is the responsibility of the [LALD] that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for

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02070	Continued From page 76 assistance with health or safety needs. Such persons will be: a. Awake; b. Located in the same building, in an attached building, or on a contiguous campus with the community in order to respond within a reasonable amount of time; c. Capable of communicating with residents; d. Capable of providing or summoning the appropriate assistance; and e. Capable of following directions. "It is the responsibility of the [RN] that a minimum of two direct-care team members are scheduled and available to assist whenever a resident requires the assistance of two direct-care team members for scheduled and reasonably foreseeable unscheduled needs, as reflected in the resident's assessments and service plan." No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	02070		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed;	02110		

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02110	Continued From page 77 (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures for assisted living with dementia care (ALFDC) were provided to residents or the resident's legal and / or designated representative at the time of move-in for four of four residents (R4, R5, R6, R7). 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	02110		

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02110	Continued From page 78 of the residents). The findings include: R4 was admitted to the licensee February 26, 2016, and started receiving assisted living services August 1, 2021. R5 was admitted to the licensee for assisted living services on December 9, 2022. R6 was admitted to the licensee on June 30, 2021, and started receiving assisted living services August 1, 2021. R7 was admitted to the licensee June 10, 2020, and started receiving assisted living services August 1, 2021. R4, R5, R6, and R7's resident records lacked evidence the licensee provided a resident or resident representative policies and procedures that addressed 144G.82 Subd. 3., at the time of move-in to the facility. On January 11, 2023, at 11:34 a.m., licensed assisted living director (LALD)-C stated none of the residents in the facility were provided policies and procedures for ALFDC. LALD-C stated they were unaware of the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02260 SS=C	144G.90 Subd. 3 Notice of dementia training An assisted living facility with dementia care shall	02260		

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02260	Continued From page 79 make available in written or electronic form, to residents and families or other persons who request it, a description of the training program and related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered. A hard copy of this notice must be provided upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who request it, an accurate description of the dementia care training program with the required content. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 9, 2023, at 10:30 a.m., licensed assisted living director (LALD)-C verified the licensee was licensed for assisted living with dementia care. In addition, the evaluator requested to see the licensee's dementia care training program. On January 11, 2023, at 11:15 a.m., after three requests, the evaluator was not provided licensee's dementia care and training program. LALD-C stated the licensee lacked a description	02260		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21787	A. BUILDING: _____ B. WING _____	01/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF EDINA	**7128 FRANCE AVENUE SOUTH EDINA, MN 55435**

(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
02260	Continued From page 80 of the dementia care program with the required content and they believed the information was removed from the contract when the licensee made a revision. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02260		

DEPARTMENT OF HEALTH

Type: Full
Date: *01/09/23*
Time: 08:22:41
Report: 1036231004

Food and Beverage Establishment Inspection Report

Location:
Sunrise Of Edina
7128 France Avenue South
Edina, MN55435
Hennepin County, 27

Establishment Info:
ID #: 0038732
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 9529278000
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.

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

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

NO WATERPROOF THERMOMETER FOR MEASURING UTENSIL SURFACE TEMP IN HIGH TEMP DISH MACHINE. OBTAIN AND MAINTAIN SUCH A DEVICE.

Comply By: 02/09/23

5-200C Plumbing: Maintenance, fixture location

5-205.11AB ** Priority 2 **

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

OBSERVED A PITCHER AND ICE IN THE KITCHEN HANDWASHING SINK. ENSURE ALL DESIGNATED HANDWASHING SINKS ARE USED FOR INTENDED PURPOSE ONLY. ISSUE CORRECTED ON SITE.

Corrected on Site

2-100 Supervision

2-102.12AMN

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

NO CURRENT CFPM AT ESTABLISHMENT. INSTRUCTIONS FOR APPLICATION SENT TO HEAD COOK ANTHONY G.

Comply By: 02/09/23

Surface and Equipment Sanitizers

Hot Water: = at 166.6 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

LACTIC ACID & DDBSA: = 272/702 at Degrees Fahrenheit
Location: 3 COMP DISPENSER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding/ZUCCHINI
Temperature: 169 Degrees Fahrenheit - Location: STEAM WELL
Violation Issued: No

Process/Item: Hot Holding/CHICKEN
Temperature: 166 Degrees Fahrenheit - Location: STEAM WELL
Violation Issued: No

Process/Item: Cold Hold/SAUSAGE
Temperature: 40 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: Cold Hold/HB EGG
Temperature: 40 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: Cold Hold/MILK
Temperature: 39 Degrees Fahrenheit - Location: SMALL TRUE FRIDGE
Violation Issued: No

Process/Item: Cold Hold/SLICE TOMATO
Temperature: 39 Degrees Fahrenheit - Location: TRUE COOLER
Violation Issued: No

Process/Item: Cold Hold/MILK
Temperature: 39 Degrees Fahrenheit - Location: TRUE REACH IN COOLER
Violation Issued: No

Process/Item: Hot Holding/SOUP
Temperature: 171 Degrees Fahrenheit - Location: SOUP WARMER
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. ALL VIOLATIONS WERE
DISCUSSED WITH PERSON IN CHARGE AND HRD EVALUATOR DURING INSPECTION.

DISCUSSED:
- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- SANITIZER USE AND TEST KITS.
- HAND WASHING POLICY AND REVIEW.
- GLOVE USAGE

- THERMOMETER USE AND CALIBRATION.
- DATE MARKING.
- PEST CONTROL.

REVIEWED THE SYMPTOMS OF FOODBORNE ILLNESSES AND THE REQUIREMENT TO MAINTAIN A DOCUMENTED RECORD OF ALL INSTANCES OF EMPLOYEES BEING ILL WITH EITHER VOMITING OR DIARRHEA AS REQUIRED BY THE MINNESOTA FOOD CODE & EXCLUDE ILL WORKERS FROM WORKING WITH FOOD & BEVERAGES UNTIL 24 HOURS AFTER SYMPTOMS HAVE ENDED.

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

I acknowledge receipt of the inspection report number 1036231004 of 01/09/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____ Signed:_____

Anthony Guerrieri
HEad cook

Jeff Johanson