Electronically Delivered

October 14, 2025

Licensee
Sunrise Of Minnetonka
18605 Old Excelsior Boulevard
Minnetonka, MN 55345

RE: Project Number(s) SL24010016

Dear Licensee:

On September 12, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on June 26, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Renee L. Anderson

Renee L. Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

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Electronically Delivered

August 19, 2025

Licensee
Sunrise of Minnetonka
18605 Old Excelsior Boulevard
Minnetonka, MN 55345

RE: Project Number(s) SL24010016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 26, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

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

St - 0 - 0340 - 144g.30 Subd. 5 - Correction Orders - $500.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required -$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

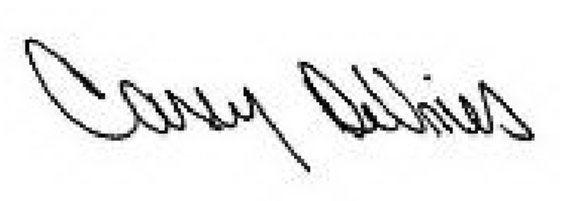
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24010	A. BUILDING: _____ B. WING _____	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF MINNETONKA	18605 OLD EXCELSIOR BOULEVARD MINNETONKA, MN 55345

(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: SL24010016-0 On June 23, 2025, through June 26, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 37 residents; 37 receiving services under the Assisted Living Facility with Dementia Care license. An immediate correction order was identified on June 24, 2025, issued for SL24010016-0, tag identification 1290. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 340 SS=F	144G.30 Subd. 5 Correction orders	0 340		

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0 340	Continued From page 1 (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a plan of correction (POC) for correction orders related to 144G.41 Subdivision (Subd.) 1., staffing plan, 144G.41 Subd. 1., food services, 144G.42 Subd. 8., staff records, 144G.42 Subd. 10., emergency preparedness, 144G.83 Subd. 3., supervised staff training and 144G.91 Subd. 4., appropriate cares and services issued during their previous routine survey on June 26, 2023, through June 27, 2023.	0 340		

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0 340	Continued From page 2 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee received their correction orders via electronic delivery on July 17, 2023, following their June 2023 survey. The longest time-period for correction on the correction orders from the date of receipt was 21-days. MN Statute 144G.30 Subd. 5 (c) (1) indicates by the correction order date; the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon complaint investigation, and as otherwise needed. On June 26-27, 2023, the Minnesota Department of Health (MDH) conducted a routine survey and re-issued correction orders for staffing plans, food services, annual performance reviews, emergency preparedness, supervised staff training and appropriate cares and services for medication administration. On June 25, 2025, at 11:25 a.m., licensed assisted living director (LALD)-D stated they did not know if a POC was completed from their previous survey and did not have documentation to provide. LALD-D stated the previous management company would have been responsible for the POC. LALD-D stated the	0 340		

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0 340	Continued From page 3 management and administrative staff had all been with the licensee for nine months or less. The current management group took over managerial duties on May 29, 2025. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and	0 470		

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0 470	Continued From page 4 (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to update their staffing plan at least twice annually. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's 2025 Staffing Plan dated June 23, 2025, completed during the survey by clinical nurse supervisor (CNS)-A, lacked evidence it was evaluated or updated at least twice a year for appropriate staffing levels in the facility. On June 23, 2025, at 9:45 a.m., during the entrance conference, licensed assisted living director (LALD)-E stated staffing was updated weekly. LALD-E stated they did not currently have an official staffing plan but one would be created soon. LALD-E stated staffing plans were developed by the CNS. On June 25, 2025, at 9:35 a.m., CNS-A stated the staffing plan they provided was the only one they had completed. CNS-A stated prior to the management company change on May 29, 2025, they had a computer system which would generate a report once per week for appropriate	0 470		

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0 470	Continued From page 5 staffing levels based on resident acuity; they stated they did not have access to those reports. CNS-A stated the previous management company wiped their software clean, so they did not have reports to provide. CNS-A stated the only staffing plan they had was created on June 23, 2025. On June 25, 2025, at 11:54 a.m., CNS-A and LALD-D stated they did not have additional staffing plans to provide. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota	0 480		

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0 480	Continued From page 6 Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.	0 480		

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0 480	Continued From page 7 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated June 24, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee on June 24, 2025. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=D	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 applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision.	0 510		

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0 510	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complied with accepted health care, medical and nursing standards for infection control. The deficient practice had the potential to affect all residents, employees, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On June 25, 2025, at 7:40 a.m., the surveyor observed unlicensed personnel (ULP)-G prepare and administer medication for R3. Without performing hand hygiene, ULP-G went to the medication cart and began R3's medication administration process. With soiled hands, ULP-G punched R3's medications out of bubble packages into a medication cup. With soiled hands, ULP-G used a pill crusher to crush R3's medications; then mixed the crushed medications with yogurt and then applied a pair of gloves to their hands without performing hand hygiene. With soiled gloves, ULP-G spoon fed the yogurt and medication to R3 touching R3 on the back with their gloved hands. ULP-G returned to the medication cart and removed their gloves; ULP-G did not perform hand hygiene. The surveyor questioned ULP-G if they had hand sanitizer available. ULP-G pulled open the middle drawer	0 510		

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0 510	Continued From page 9 of the medication cart which contained a bottle of hand sanitizer and stated, "it's right here". ULP-G closed the drawer without using the hand sanitizer. At 7:48 a.m., the surveyor observed ULP-G move directly from R3's medication administration to prepare and administer medications for R4. ULP-G did not apply gloves. With soiled hands, ULP-G punched R4's medications out of bubble packages into a medication cup. With soiled hands, ULP-G used a pill crusher to crush R4's medications; then mixed the crushed medications with yogurt. With soiled hands, ULP-G spoon fed the yogurt and medication to R4 touching R4's arm and back. ULP-G went to the commons area kitchen and washed their hands in the sink; it was the first time ULP-G performed hand hygiene since observation began at 7:40 a.m. ULP-G stated it was their understanding they only needed to perform hand hygiene if they directly touched a resident. ULP-G stated they did not wash their hands after administering R3's medications because they wore gloves and were washing their now because they touched R4 with bare hands. ULP-G stated they were trained on hand hygiene by one of the nurses when they were hired. On June 25, 2025, at 11:54 a.m., clinical nurse supervisor (CNS)-A stated ULP-G did not follow the correct hand hygiene procedure and should have performed hand hygiene between tasks and after removing their gloves. CNS-A stated they were in the process of retraining all of their staff. The Center for Disease Control (CDC) Hand Hygiene Guidance last reviewed on April 12, 2024, indicated, "1. Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations.	0 510		

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0 510	Continued From page 10 2. Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a. Immediately before touching a patient b. Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices c. Before moving from work on a soiled body site to a clean body site on the same patient d. After touching a patient or the patient's immediate environment e. After contact with blood, body fluids or contaminated surfaces f. Immediately after glove removal 3. Ensure that healthcare personnel perform hand hygiene with soap and water when hands are visibly soiled. 4. Ensure that supplies necessary for adherence to hand hygiene are readily accessible in all areas where patient care is being delivered." The licensee's Hand Washing policy dated October 15, 2024, indicated "When hands should be washed using soap and water: Team members will wash hands between resident care and whenever direct physical contact with a resident takes place. Use of gloves does not replace hand washing. Hands will be washed: - Before and after direct care of a resident - If moving from a contaminated body site to a clean body site during resident care - After contact with surfaces or equipment in the immediate vicinity of the resident - Before applying and after removing personal protective equipment (PPE) - Before eating or preparing food - After using a restroom - When hands look dirty" No further information was provided.	0 510		

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0 510	Continued From page 11 TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included annual performance review documentation for one of one employee due for an annual performance review (unlicensed personnel (ULP)-C).	0 650		

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0 650	Continued From page 12 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-C was hired on August 10, 2022, to provide direct cares to residents. ULP-C's employee record lacked evidence an annual performance review was completed. On June 23, 2025, at 10:05 a.m., the surveyor observed ULP-C assisting during a fire drill; they assisted residents out of the building and obtained a fire extinguisher. On June 24, 2025, the surveyor observed ULP-C providing services to residents throughout the day. On June 24, 2025, at 1:09 p.m., ULP-C stated they had not received an annual performance evaluation since they were hired by the licensee. On June 25, 2025, at 11:54 a.m., licensed assisted living director (LALD)-E stated they were unable to locate an annual performance review for ULP-C. LALD-E stated the previous management group took the majority of employee records when they left and did not know if a performance review had been completed; they were unsure if any employees had annual performance reviews. LALD-E stated they had	0 650		

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0 650	Continued From page 13 not completed any annual performance reviews since their management group took over on May 29, 2025. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to conduct a tuberculosis (TB) symptom screening for one of two employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 660		

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0 660	Continued From page 14 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: The licensee's TB risk assessment was completed on January 9, 2025. The licensee was at a low risk level. ULP-C was hired on October 10, 2022, to provide direct cares to residents. ULP-C's employee record lacked a baseline TB symptom screening. On June 24, 2025, the surveyor observed ULP-C providing services to residents throughout the day. On June 26th, 2025, at 7:54 a.m., licensed assisted living director (LALD)-E stated they were unable to locate a symptom screening for ULP-C. LALD-E stated the previous management group took many of the records with them when they transitioned to the current management group. The Minnesota Department of Health TB FAQ, last updated on December 13, 2024, indicated baseline TB screening is required at the time of hire for all health care personnel in Minnesota which included: - assessing for current symptoms of active TB disease; - assessing TB history; and - testing for the presence of Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or single TB blood test.	0 660		

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0 660	Continued From page 15 The licensee's Communicable Disease Screening Tool indicated, "Team members and volunteers will be screened for communicable diseases prior to direct contact with residents and annually (if required by law)." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional	0 680		

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0 680	Continued From page 16 requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content for staff, residents, and visitors to view. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 24, 2025, at 12:15 p.m., the surveyor reviewed the licensee's Emergency Preparedness and Response Program, it was undated and was not tailored to the licensee. The EPP lacked the following: -reviewed/updated annually; -all-hazards risk assessment; -arrangements/contracts to re-establish utility services; -missing resident policy review every three months; -identified evacuation transportation; -identified evacuation location; -include a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; -includes policies/procedures (P/P) for at minimum food, water, and pharmaceutical supplies.	0 680		

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0 680	Continued From page 17 -address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; -develop P/P to address: system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; -communication plan must include contact information for the following: -federal, state, tribal, regional & local EP staff -state licensing and certification agency -MN Office of Ombudsman for Long Term Care; -method for sharing information and medical documentation for residents under the facility's care, as necessary, with other health care providers to maintain continuity of care; -means, in event of evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii) -means of providing information about general condition/ location of residents under the facility's care as permitted under 45 CFR 164.510(b)(4) -training program must include all of the following: -initial training in EP P/P to all new and existing staff, individuals providing services under arrangement, and volunteers consistent with their expected role -provide EP training at least annually -maintain documentation of all EP training -demonstrate staff knowledge of EP; and -documentation of conducted exercises to test the EP at least twice per year, including unannounced staff drills using the EPP. On June 23, 2025, at approximately 10:05 a.m., during the entrance conference, a fire alarm sounded throughout the building. Licensed assisted living director (LALD)-E stated they did not think it was a drill as they just had a fire drill	0 680		

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0 680	Continued From page 18 last week. Emergency fire services arrived at 10:22 a.m. At 10:46 a.m., a fireman said there was smoke coming from a dryer in the second-floor laundry room. On June 26, 2025, at 7:54 a.m., LALD-E stated they developed a primary EPP for all of their properties and then tailor it to each of their building's needs. LALD-E stated they did not think it had been tailored to the facility needs yet since their management group took over for the previous management group on May 29, 2025. The surveyor requested drills and training documentation for the EPP, LALD-E stated it may be a problem to find them since the previous management group did not leave them behind. The licensee's EPP policy, undated, indicated " The Community's Emergency Preparedness and Response Program was designed with an all-hazards approach to planning. This means that developing the program began with a comprehensive list of all possible disasters, regardless of their likelihood, geographic impact, or potential outcome. This all-hazards approach will be based on the hazards that are most likely to affect the Community. A Hazard and Risk Assessment is completed to determine the most likely hazards and their potential impact on the Community. The Emergency Preparedness and Response Program will guide the Community on how appropriate responses may unfold and what the correct actions would be. " No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 720	Continued From page 19	0 720		
0 720 SS=F	144G.43 Subd. 2 Access to records The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure that facility assessments, facility records, employee records, and resident records were readily available for timely access to employees, vendors, and the commissioner authorized to access the records. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 29, 2025, the licensee had a change in management groups. The licensee removed the previous management group and replaced them with the current management group. The licensee lacked access to the following documents: -resident assessments; -staffing plans;	0 720		

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0 720	Continued From page 20 -facility records; -employee records including initial orientation training, annual training, dementia training, RN 30-day supervision, competency and treatment training; -emergency preparedness plan (EPP) staff training and drills; and -plan of correction from their previous survey. On June 23, 2025, at 12:09 p.m., clinical nurse supervisor (CNS)-A stated they were unable to provide R6's discharge summary and medication disposition because they did not have them. CNS-A stated a record storage and disposal company was storing records for the previous management group who took the majority of facility, staff, and resident records. CNS-A stated the previous management group used PointClickCare (PCC) (charting software) and they did not have access to resident records as they did not have access to the previous management group's PCC. On June 25, 2025, at 9:35 a.m., CNS-A stated they only had one record of one Staffing Plan created on June 23, 2025, during the survey. CNS-A stated under the previous management group the computer system would generate a report once per week to identify staffing needs based on resident acuity. CNS-A stated they did not have those reports as the previous management group wiped the software clean before they left. On June 25, 2025, at 10:13 a.m., CNS-A stated finding assessments for R2 and R3 was challenging since the previous management group took many of their records with them including staff and resident records.	0 720		

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0 720	Continued From page 21 On June 25, 2025, at 11:25 a.m., licensed assisted living director (LALD)-D stated they did not know if they did not have access to plan of correction (POC) documentation from their previous survey conducted on June 26, 2023, through June 27, 2023. CNS-A stated the POC would have been the responsibility of the previous management group who took records with them when they left. On June 25, 2025, at 11:54 a.m., LALD-D and CNS-A stated they only had no additional staffing plans to provide. LALD-D, LALD-E, and CNS-A all agreed record access was a problem and a contributing factor to the problems the surveyor identified during the survey including employee records, resident records, and facility records. On June 26, 2025, at 7:54 a.m., LALD-E stated they developed a primary EPP for all of their properties and then tailor it to each of their building's needs. LALD-E stated they did not think it had been tailored to the facility needs yet since their management group took over for the previous management group. The surveyor requested drills and training documentation for the EPP, LALD-E stated it may be a problem to find them since the previous management group did not leave them behind. LALD-E stated they were unable to find unlicensed personnel (ULP)-C's tuberculosis (TB) screening, ULP-B and ULP-C's RN 30-day supervision, and ULP-G's hand washing training. LALD-E stated, at this point, if documents had not been provided, they either did not get completed or they could not find them from the previous management group who took the majority resident and staff records with them. The licensee was able to gain access to resident	0 720		

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0 720	Continued From page 22 records via the previous management group's PCC during the survey but were unaware they had access to the records prior to the surveyor's request. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 720		
0 775 SS=E	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511. 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 June 26, 2025, at 12:00 p.m., the surveyor toured the facility with environmental services director (ESD)-J. During the facility tour, the surveyor observed the following: Controlled Egress Door Locking System	0 775		

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0 775	Continued From page 23 Electromagnetic locks were installed on the emergency exit doors. Keypads were installed at these doors and required entry of a code into the keypad to unlock. A switch or device was not installed at the nurse station or other approved location that had the capability to break power to all locked doors. During the facility tour interview on June 26, 2025, ESD-J verified the above listed locking observations. Controlled egress door locking systems must comply with Minnesota State Fire Code Rules, Chapter 7511. On June 26, 2025, licensed assisted living director (LALD)-E and ESD-J provided emergency plan documents. Record review indicated the emergency plan did not include procedures to operate and unlock the controlled egress door locking system. During an interview on June 26, 2025, at approximately 2:30 p.m., ESD-J verified these instructions were not included in the emergency plan. Smoking Material Disposal Burnt cigarettes and plastic cups were disposed of in an uncovered metal bucket with a plastic liner on the exterior patio near the back of the building. During a facility tour interview on June 26, 2025, ESD-J verified the above listed smoking material observations. ESD-J stated there was a proper disposal container available for residents to use in the courtyard. Improper disposal of smoking materials creates a fire hazard. Emergency Exit Sign Maintenance One emergency exit sign was not illuminated in the third floor dining room. During a facility tour interview on June 26, 2025, ESD-J verified the above listed dining room observation. All exit signs must be maintained in operable condition to ensure sufficient illumination will be provided to allow the building occupants to safely evacuate in the event of an emergency.	0 775		

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0 775	Continued From page 24 Electrical Three exterior electrical wall outlets were not provided with covers on the back of the building. During a facility tour interview on June 26, 2025, ESD-J verified the above listed electrical observations. Weatherproof covers for electrical outlets are required in outdoor locations to prevent water damage, electrical shocks, and fires. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	0 780		

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0 780	Continued From page 25 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On June 26, 2025, at 12:00 p.m., the surveyor toured the facility with environmental services director (ESD)-J. During the facility tour, the surveyor observed smoke alarms were not installed outside the resident sleeping rooms in units 201 and 301. Smoke detectors not equipped with horn strobes or audible speaker bases were installed outside these sleeping rooms. During an interview on June 26, 2025, at approximately 2:30 p.m., ESD-J verified the above listed smoke alarm and smoke detector observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		

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0 810	Continued From page 26	0 810		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	0 810		

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0 810	Continued From page 27 Based on record review and interview, the licensee failed to develop the fire safety and evacuation plan with required content and provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 26, 2025, environmental services director (ESD)-J and licensed assisted living director (LALD)-E provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN Record review of the available documentation indicated the licensee failed to develop the FSEP with site specific procedures. The FSEP included a New Perspectives fire response plan template. The FSEP included standard employee procedures but failed to include site specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. During an interview on June 26, 2025, at 2:45 p.m., LALD-E verified the FSEP needed revision and stated they were not aware site specific employee actions were required.	0 810		

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0 810	Continued From page 28 TRAINING Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year evident by a lack of documentation to support this training had been completed. The surveyor requested documentation to support residents received training in the past year on fire safety and evacuation from LALD-E. No training records for 2024 or 2025 were provided. Record review indicated the licensee failed to provide training to employees on the FSEP at least twice per year evident by a lack of documentation to support this training was completed. The surveyor requested documentation to support employee training on the site specific FSEP had been completed in the past year from LALD-E. No training records for 2024 or 2025 were provided. During an interview on June 26, 2025, at approximately 2:45 a.m., LALD-E stated because the facility had recently changed ownership these past training records were not available. LALD-E provided a copy of a new hire checklist that included fire safety and evacuation as a training topic and stated employees were currently in the process of completing this training. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month evident by a review of fire drill reports lacking the required frequency and documentation. The surveyor requested evacuation drill records for the time period June 2024 to June 2025. Nine drill records were provided. The shift or time of the drill was not recorded on the 2024 reports for July, August, and September. No drill records were provided for March or April 2025. During an interview on	0 810		

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0 810	Continued From page 29 June 26, 2025, at 11:45 a.m., ESD-J verified the frequency was not met and the fire drill logs were lacking the required information. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01290 SS=G	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure they received a background study (BGS) clearance from NETStudy 2.0 (web-based system use to submit BGS requests to the Department of Human Services (DHS)) in affiliation with the assisted living licensee's health facility identification number (HFID) for one of two employees (cook (C)-F).	01290		

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01290	Continued From page 30 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: The licensee's HFID was 24010. C-F was hired on July 30, 2021, to prepare and cook food for residents. The licensee's employee roster indicated C-F was a current employee for the licensee. The licensee's NETStudy 2.0 report completed on June 23, 2025, indicated C-F had a COVID expired BGS. The licensee's Location Schedule -Weekly executed on June 23, 2025, indicated C-F was scheduled to work on June 26-28, 2025, and July 1-5, 2025. On June 24, 2025, at 10:44 a.m., licensed assisted living director (LALD)-E, who was also the regional director of operations, stated the NETStudy 2.0 report was run on June 24, 2025. LALD-E stated C-F was a currently employed by the licensee as a cook and had a COVID-19 expired BGS which was not rerun when it expired. LALD-E stated the previous management company did not rerun the report when it expired; and their management company took over duties for the licensee on May 29, 2025. LALD-E stated	01290		

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01290	Continued From page 31 they were conducting a BGS audit immediately for all of their staff. The DHS website for Background Studies updated June 16, 2025, indicated, "The Minnesota Department of Human Services (DHS) requires background studies for people who work in certain health and human services programs, and in childcare settings if they provide care or have direct contact with vulnerable populations. DHS also completes background studies on others, such as people planning to provide foster care or adopt. Minnesota statutes direct the background study process for entities required to initiate background studies." It further indicated, "DHS temporarily modified background studies during the COVID-19 pandemic. Those modifications ended Jan. 1, 2023. Learn more about the return to fully compliant studies." The licensee's Background Checks policy dated February 14, 2022, indicated, "Background checks must be conducted on all final candidates after a job offer is extended. Background check guidelines vary by state and job relatedness (e.g., driving records should only be checked for those expected to drive as part of their job duties), and are designed to be cost effective. Background check authorization forms should only be given to final candidates after a conditional job offer has been extended. Candidates must sign the background release form to initiate a background check. The recruiter at the Resource Center or business office manager (BOM) is responsible for monitoring and notifying the executive director (ED) or hiring manager of hiring status. The Community's ED is responsible for ensuring all	01290		

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01290	Continued From page 32 final candidates meet background check requirements." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences,	01370		

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01370	Continued From page 33 cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for two of two employees (unlicensed personnel (ULP)-B, ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was hired on October 9, 2024, to provide direct cares to residents. ULP-B's record lacked the following competency training and competency evaluations: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the assisted living	01370		

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01370	Continued From page 34 provider; - appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing (ii) care of teeth, gums, and oral prosthetic devices (iii) care and use of hearing aids (iv) dressing and assisting with toileting - training on the prevention of falls for providers working with the elderly or individuals at risk of falls; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; - awareness of confidentiality and privacy; - understanding appropriate boundaries between staff and residents and the resident's family; - procedures to utilize in handling various emergency situations; and - awareness of commonly used health technology equipment and assistive devices. ULP-C ULP-C was hired on August 10, 2022, to provide direct cares to residents. ULP-C's record lacked the following competency training and competency evaluations: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the assisted living	01370		

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01370	Continued From page 35 provider; - appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing (ii) care of teeth, gums, and oral prosthetic devices (iii) care and use of hearing aids (iv) dressing and assisting with toileting - training on the prevention of falls for providers working with the elderly or individuals at risk of falls; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; - awareness of confidentiality and privacy; - understanding appropriate boundaries between staff and residents and the resident's family; - procedures to utilize in handling various emergency situations; and - awareness of commonly used health technology equipment and assistive devices. On June 23, 2025, at 10:05 a.m., the surveyor observed ULP-C assisting during a fire drill; they assisted residents out of the building and obtained a fire extinguisher. On June 24, 2025, the surveyor observed ULP-B and ULP-C providing services to residents. On June 24, 2025, at 1:01 p.m., ULP-B stated they did not have any official competency training	01370		

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01370	Continued From page 36 when they were hired. ULP-B stated the competency training they received was from other ULPs during shadow shifts. ULP-B stated they were recently assigned competency training online by the new management group but had not had the time to complete them. On June 24, 2025, at 1:09 p.m., ULP-C stated they did not receive competency training when they were hired. ULP-C stated they learned their competencies on the job while shadowing another ULP. ULP-C stated the previous management group was doing a very poor job of training them. ULP-C sated new trainings had been assigned to them but hadn't started them yet. ULP-C stated they were pulling him off the floor some today to start the assigned online trainings. On June 25, 2025, at 11:54 a.m., licensed assisted living director (LALD)-D and clinical nurse supervisor (CNS)-A stated competency training was a widespread problem they needed to address; ULP-B and ULP-C's competency training would have been completed by the previous management group who took the majority of staff records with them. LALD-E stated moving forward all employees were going to be treated like, "new employees," and receive new competency training. The licensee's Team Member Orientation and Training policy dated January 27, 2023, indicated: "Training and competency evaluations to be completed prior to team members providing care services include: · Documentation requirements for all services provided; · Reports of changes in the resident ' s condition to the supervisor designated by the	01370		

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01370	Continued From page 37 facility; · Basic infection control, including blood-borne pathogens; · Maintenance of a clean and safe environment; · Appropriate and safe techniques in personal hygiene and grooming, including: o Hair care and bathing; o Care of teeth, gums, and oral prosthetic devices; o Care and use of hearing aids; and o Dressing and assisting with toileting. · Training on the prevention of falls; · Standby assistance techniques and how to perform them; · Medication, exercise, and treatment reminders; All policies are subject to amendment. Refer to the New Perspective intranet for the most recent version. Team Member Orientation and Training Page 3 of 6 · Basic nutrition, meal preparation, food safety, and assistance with eating; · Preparation of modified diets as ordered by a licensed health professional; · Communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; · Awareness of confidentiality and privacy; · Understanding appropriate boundaries between staff and residents and the resident's family; · Procedures to use in handling various emergency situations; · Awareness of commonly used health technology equipment and assistive devices; · Observing, reporting, and documenting resident status;	01370		

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01370	Continued From page 38 · Basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; · Reading and recording temperature, pulse, and respirations of the resident; · Recognizing physical, emotional, cognitive, and developmental needs of the resident; · Safe transfer techniques and ambulation; and · Range of motioning and positioning." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced	01380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24010	A. BUILDING: _____ B. WING _____	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF MINNETONKA	18605 OLD EXCELSIOR BOULEVARD MINNETONKA, MN 55345

(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
01380	Continued From page 39 by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for two of two employees (unlicensed personnel (ULP)-B, ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was hired on October 9, 2024, to provide direct cares to residents. ULP-B's record lacked the following competency training and competency evaluations: -observation, reporting, and documenting of resident status; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -reading and recording temperature, pulse, and respirations of the resident; -recognizing physical, emotional, cognitive, and developmental needs of the resident; -safe transfer techniques and ambulation; -range of motioning and positioning; -administering medications or treatments as required; and -other RN/professionally delegated tasks (i.e.,	01380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01380	Continued From page 40 monitor vital signs, catheter or stoma care, Broda chair, mechanical lifts). ULP-C ULP-C was hired on August 10, 2022, to provide direct cares to residents. ULP-C's record lacked the following competency training and competency evaluations: -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -reading and recording temperature, pulse, and respirations of the resident; -recognizing physical, emotional, cognitive, and developmental needs of the resident; -range of motioning and positioning; -administering medications or treatments as required; and -other RN/professionally delegated tasks (i.e., monitor vital signs, catheter or stoma care, Broda chair, mechanical lifts). On June 23, 2025, at 10:05 a.m., the surveyor observed ULP-C assisting during a fire drill; they assisted residents out of the building and obtained a fire extinguisher. On June 24, 2025, the surveyor observed ULP-B and ULP-C providing services to residents. On June 24, 2025, at 1:01 p.m., ULP-B stated they did not have any official competency training when they were hired. ULP-B stated the competency training they received was from other ULPs during shadow shifts. ULP-B stated they were recently assigned competency training online by the new management group but had not had the time to complete them.	01380		

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01380	Continued From page 41 On June 24, 2025, at 1:09 p.m., ULP-C stated they did not receive competency training when they were hired. ULP-C stated they learned their competencies on the job while shadowing another ULP. ULP-C stated the previous management group was doing a very poor job of training them. ULP-C sated new trainings had been assigned to them but hadn't started them yet. ULP-C stated they were pulling him off the floor some today to start the assigned online trainings. On June 25, 2025, at 11:54 a.m., licensed assisted living director (LALD)-D and clinical nurse supervisor (CNS)-A stated competency training was a widespread problem they needed to address; ULP-B and ULP-C's competency training would have been completed by the previous management group who took the majority of staff records with them. LALD-E stated moving forward all employees were going to be treated like, "new employees," and receive new competency training. The licensee's Team Member Orientation and Training policy dated January 27, 2023, indicated: "Training and competency evaluations to be completed prior to team members providing care services include: · Documentation requirements for all services provided; · Reports of changes in the resident's condition to the supervisor designated by the facility; · Basic infection control, including blood-borne pathogens; · Maintenance of a clean and safe environment; · Appropriate and safe techniques in personal	01380		

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01380	Continued From page 42 hygiene and grooming, including: o Hair care and bathing; o Care of teeth, gums, and oral prosthetic devices; o Care and use of hearing aids; and o Dressing and assisting with toileting. · Training on the prevention of falls; · Standby assistance techniques and how to perform them; · Medication, exercise, and treatment reminders; All policies are subject to amendment. Refer to the New Perspective intranet for the most recent version. Team Member Orientation and Training Page 3 of 6 · Basic nutrition, meal preparation, food safety, and assistance with eating; · Preparation of modified diets as ordered by a licensed health professional; · Communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; · Awareness of confidentiality and privacy; · Understanding appropriate boundaries between staff and residents and the resident's family; · Procedures to use in handling various emergency situations; · Awareness of commonly used health technology equipment and assistive devices; · Observing, reporting, and documenting resident status; · Basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; · Reading and recording temperature, pulse, and respirations of the resident;	01380		

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01380	Continued From page 43 · Recognizing physical, emotional, cognitive, and developmental needs of the resident; · Safe transfer techniques and ambulation; and · Range of motioning and positioning." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced	01440		

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01440	Continued From page 44 by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for two of two employees (unlicensed personnel (ULP)-B, ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was hired on October 9, 2024, to provide direct cares to residents. ULP-B's employee record lacked evidence a RN 30-day supervision was completed. ULP-C ULP-C was hired on August 10, 2022, to provide direct cares to residents. ULP-C's employee record lacked evidence a RN 30-day supervision was completed. On June 23, 2025, at 10:05 a.m., the surveyor observed ULP-C assisting during a fire drill; they assisted residents out of the building and obtained a fire extinguisher. On June 24, 2025, the surveyor observed ULP-B and ULP-C providing services to residents.	01440		

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01440	Continued From page 45 On June 24, 2025, at 1:01 p.m., ULP-B stated they did not have any official competency training when they were hired. ULP-B stated the competency training they received was from other ULPs during shadow shifts. ULP-B stated a nurse had not performed an observation or supervision of them performing delegated tasks. On June 24, 2025, at 1:09 p.m., ULP-C stated they did not receive competency training when they were hired. ULP-C stated they learned their competencies on the job while shadowing another ULP. ULP-C stated the previous management group was doing a very poor job of training them. ULP-C stated a nurse had not performed an observation or supervision of them performing delegated tasks. On June 25, 2025, at 11:54 a.m., clinical nurse supervisor (CNS)-A stated they were unsure if RN 30-day supervisions were completed for ULP-B and ULP-C as they would have been completed by the previous management group who took the majority of staff records with them. LALD-E stated moving forward all employees were going to be treated like, "new employees," and would receive new training and RN 30-day supervisions. The licensee's Team Member Supervision policy dated October 6, 2024, indicated, "Team members must be supervised by the nurse within 30 days of date of delegation and thereafter as warranted based on performance. This requirement also applies to team members who have not performed delegated tasks for one (1) year or longer." No further information was provided.	01440		

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01440	Continued From page 46 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
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 staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a),	01470		

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01470	Continued From page 47 orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees completed required orientation before providing services for two of two unlicensed direct care employees (unlicensed personnel (ULP)-B, ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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	01470		

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01470	Continued From page 48 of the residents). The findings include: ULP-B ULP-B was hired on October 9, 2024, to provide direct cares to residents. ULP-B's employee record lacked evidence orientation was completed for the following topics: -Overview of Assisted Living statutes; -Review of provider's policies and procedures; -Handling emergencies and using emergency services; -Assisted Living Bill of Rights; -Handing of resident complaints, reporting of complaints, where to report; -Consumer advocacy services; -Review of types of Assisted Living services the employee will provide and provider's scope of license; -Principles of person-centered planning/service delivery; and -Hearing loss training (optional). ULP-C ULP-C was hired on August 10, 2022, to provide direct cares to residents. ULP-C's employee record lacked evidence orientation was completed for the following topics: -Overview of Assisted Living statutes; -Review of provider's policies and procedures; -Assisted Living Bill of Rights; -Handing of resident complaints, reporting of complaints, where to report; -Consumer advocacy services; -Review of types of Assisted Living services the employee will provide and provider's scope of license;	01470		

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01470	Continued From page 49 -Principles of person-centered planning/service delivery; and -Hearing loss training (optional). On June 23, 2025, at 10:05 a.m., the surveyor observed ULP-C assisting during a fire drill; they assisted residents out of the building and obtained a fire extinguisher. On June 24, 2025, the surveyor observed ULP-B and ULP-C providing services to residents. On June 24, 2025, at 1:01 p.m., ULP-B stated they did not receive training for the above-mentioned orientation topics. ULP-B stated they were assigned online training by the current management group but had not had time to complete it. On June 24, 2025, at 1:09 p.m., ULP-C stated they did not receive training for the above-mentioned orientation topics. ULP-C stated they were assigned online training by the current management group but had not had time to complete it. On June 25, 2025, at 11:54 a.m., licensed assisted living director (LALD)-D orientation was a widespread problem they needed to address; ULP-B and ULP-C's orientation should have been completed by the previous management group who took the majority of staff records with them. LALD-E stated moving forward all employees were going to be treated like, "new employees," and receive new orientation training. The licensee's Team Member Orientation and Training policy dated November 5, 2021, indicated: "Orientation conducted prior to all team members	01470		

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01470	Continued From page 50 performing job duties will consist of TMO: NP Orientation, TMO: Care Skills, TMO: Understanding Dementia, role-specific onboarding (to include the team member's job description and an organizational chart), and specific resident orientation. It will include: · Overview of regulatory training requirements; · Introduction and review of the Community's policies and procedures related to the provision of assisted living services; · Handling of emergencies and use of emergency services; · Compliance with and reporting of maltreatment of vulnerable adults to the Minnesota Adult Abuse Reporting Center (MAARC); · Assisted living bill of rights and team member responsibilities related to ensuring the exercise and protection of those rights; · Principles of person-centered planning and service delivery and how they apply to direct support services provided by the team member; · Handling of residents' complaints, reporting of complaints, and where to report complaints; · 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 · Review of the types of assisted living services the team member will be providing and the Community's category of licensure, as documented in the Uniform Disclosure of Assisted Living Services and Amenities." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01470		

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01470	Continued From page 51 (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 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),	01500		

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SUNRISE OF MINNETONKA	18605 OLD EXCELSIOR BOULEVARD MINNETONKA, MN 55345

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01500	Continued From page 52 annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment on required annual training topics for one of one employee who was employed more than 12 months (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24010	A. BUILDING: _____ B. WING _____	06/26/2025

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SUNRISE OF MINNETONKA	18605 OLD EXCELSIOR BOULEVARD MINNETONKA, MN 55345

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01500	Continued From page 53 The findings include: ULP-C was hired on August 10, 2022, to provide direct cares to residents. ULP-C's employee record lacked evidence annual training was completed for the following required topics: -Assisted Living Bill of Rights; -Effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; -Review of provider's policies and procedures; -Principles of person-centered planning/service delivery; and -Hearing loss training (optional). On June 23, 2025, at 10:05 a.m., the surveyor observed ULP-C assisting during a fire drill; they assisted residents out of the building and obtained a fire extinguisher. On June 24, 2025, the surveyor observed ULP-C providing services to residents throughout the day. On June 24, 2025, at 1:09 p.m., ULP-C stated they did not receive annual training for the above-mentioned topics. ULP-C stated they were assigned online training by the current management group but had not had time to complete it. On June 25, 2025, at 11:54 a.m., licensed assisted living director (LALD)-D annual training was a widespread problem they needed to address; ULP-C's orientation should have been	01500		

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01500	Continued From page 54 completed by the previous management group who took the majority of staff records with them. LALD-E stated moving forward all employees were going to be treated like, "new employees," and receive annual training. The licensee's Team Member Orientation and Training policy dated November 5, 2021, indicated: "Training on reporting of maltreatment of vulnerable adults; · Review of the assisted living bill of rights and team member responsibilities related to ensuring the exercise and protection of those rights; · Review of infection control techniques and implementation of infection control standards including: o Review of hand washing techniques; o The need for and use of protective gloves, gowns, and masks; o Appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; o Disinfecting reusable equipment and environmental surfaces; and o Reporting communicable diseases. · Effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; · Review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and · The principles of person-centered planning and service delivery and how they apply to direct support services provided by the team member." No further information was provided.	01500		

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01500	Continued From page 55 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01540 SS=F	144G.64 (a) (3) Training in Dementia, Mental Illness, and De- (3) for assisted living facilities with dementia care, direct-care staff must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, the staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two hours of required initial dementia care training, eight hours within 80 hours of an employee's start date, was completed for two of two direct-care employees (unlicensed personnel (ULP)-B, ULP-C).	01540		

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01540	Continued From page 56 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: ULP-B ULP-B was hired on October 9, 2024, to provide direct cares to residents. ULP-B's training transcript (untitled) indicated ULP-B received one hour of dementia care training. ULP-C ULP-C was hired on August 10, 2022, to provide direct cares to residents. ULP-C's training transcript (untitled) indicated ULP-C received three hour of dementia care training. On June 23, 2025, at 10:05 a.m., the surveyor observed ULP-C assisting during a fire drill; they assisted residents out of the building and obtained a fire extinguisher. On June 24, 2025, the surveyor observed ULP-B and ULP-C providing services to residents. On June 24, 2025, at 1:01 p.m., ULP-B stated they did not receive initial dementia training. ULP-B stated they were assigned online training by the current management group but had not	01540		

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01540	Continued From page 57 had time to complete it. On June 24, 2025, at 1:09 p.m., ULP-C stated they did not receive initial dementia training. ULP-C stated they were assigned online training by the current management group but had not had time to complete it. On June 25, 2025, at 11:54 a.m., licensed assisted living director (LALD)-D dementia training was a widespread problem they needed to address; ULP-B and ULP-C's initial dementia training should have been completed by the previous management group who took the majority of staff records with them. LALD-E stated moving forward all employees were going to be treated like, "new employees," and receive new dementia training. The licensee's Team Member Orientation and Training policy dated November 5, 2021, indicated the following for dementia care training, "Direct-care team members will have completed at least eight (8) hours of initial training on the below topics upon hire, within 80 working hours of the employment start date." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a	01620		

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01620	Continued From page 58 nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) 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. (f) A facility must inform the prospective resident of the availability of and contact information for	01620		

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01620	Continued From page 59 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a comprehensive admission, 14-day, and 90-day assessment for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted to the licensee on June 9, 2023. R2's service plan (untitled) signed June 10, 2023, indicated R2 received services for medication management, transportation, meals, transfers, bathing, bathroom assistance, and activities of daily living (ADLs). R2's record included a MN 3.0 SEHA-V10 initial assessment completed on June 9, 2023. R2's record lacked a 14-day assessment. The next comprehensive assessment documented was a MN 3.0 SEHA-V10 six-month assessment completed on November 25, 2024.	01620		

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01620	Continued From page 60 R2's record included a MN Wellness and Supervisory Visit-V3 assessment dated February 15, 2025, which was not a comprehensive assessment; the next comprehensive assessment MN 3.0 SEHA-V10 was not completed until May 16, 2025, 109 days later. The wellness assessment content did not cover the Uniform Assessment Tool requirements noted in MN Rule 4659.0150 Subp.2., and only included the following information: -vital signs; -weight; -pain; -supervisory visit information; -whether or not the resident was self-administering medications; and -summary of the residents progress since last Wellness Visit. R3 R3 was admitted to the licensee on January 14, 2025. R3's service plan (untitled) signed on January 17, 2025, indicated R3 received services for medication management, meal assistance, mechanical soft diet and honey thickened liquids, bathing assistance, and ADLs. R3's record lacked an admission assessment. R3's first documented assessment MN 3.0 SEHA-V10 for change of condition (COC) was completed on January 30, 2025, or 16 days after they were admitted. R3's next assessment MN 3.0 SEHA-V11 for COC was completed on May 12, 2025, or 102 days after the previous assessment on January 30, 2025. On June 25, 2025, at 7:14 a.m., the surveyor	01620		

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01620	Continued From page 61 observed unlicensed personnel (ULP) providing meal assistance for R3. On June 25, 2025, at 7:40 a.m., the surveyor observed ULP-G administer medications for R3. On June 23, 2025, at 9:45 a.m., during the entrance conference, clinical nurse supervisor (CNS)-A stated they conduct a comprehensive preassessment, an assessment at the time of admission, then a 14-day assessment, followed by a quarterly assessment as well as with COC. On June 25, 2025, 10:13 a.m., CNS-A stated they were only doing comprehensive assessments every 180 days instead of the required 90 days. CNS-A stated the previous management company insisted they do a comprehensive assessment every 180 days and in between those comprehensive assessment they only needed to do the noncomprehensive wellness assessment. CNS-A stated they knew it was wrong, but it was what the management company wanted them to do. They were working on finding additional assessments for R2 and R3 but it had been challenging since the previous management company took a lot of records with them. Licensed assisted living director (LALD)-E stated R2's most recent assessment was completed after their new management company took over. The licensee's Assessment and Evaluations policy dated June 24, 2025, (updated during the survey), indicated an initial comprehensive assessment should be completed prior to the initiation of nursing services, within 14 days of the start of services, after a COC, and no more than 90 days from the most recent assessment. No additional information was provided.	01620		

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01620	Continued From page 62 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure unlicensed personnel (ULP) were trained by a registered nurse (RN) and demonstrated competency prior to providing treatments for two of two employees (ULP-B, ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01950		

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01950	Continued From page 63 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: R7 was admitted to the licensee on January 29, 2018. R7's Service Plan Report dated June 2, 2025, indicated received vital signs and TED hose (compression stockings) to be administered by ULPs at the direction of a licensed nurse. On June 25, 2025, at 10:35 a.m., the surveyor observed R7 wearing their TED hose. ULP-B ULP-B was hired on October 9, 2024, to provide direct cares to residents. ULP-B's employee record lacked evidence they were trained by a nurse to provide the following treatments: -vital signs; and -TED hose. ULP-C ULP-C was hired on August 10, 2022, to provide direct cares to residents. ULP-C's employee record lacked evidence they were trained by a nurse to provide the following treatments: -vital signs; and -TED hose. On June 24, 2025, the surveyor observed ULP-B	01950		

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01950	Continued From page 64 and ULP-C providing services to residents. On June 24, 2025, at 1:01 p.m., ULP-B stated they did not receive any treatment administration training from a nurse; they were shown how to complete treatments during shadow shifts with other ULPs. On June 24, 2025, at 1:09 p.m., ULP-C stated they did not receive any treatment administration training from a nurse; they were shown how to complete treatments during shadow shifts with other ULPs. On June 25, 2025, at 11:54 a.m., licensed assisted living director (LALD)-D training was a widespread problem they needed to address; ULP-B and ULP-C's trainings, including treatments, should have been completed by the previous management group who took the majority of staff records with them. LALD-E stated all employees were going to be treated like, "new employees," and receive all new training. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01950		

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

Food & Beverage Inspection Report

Establishment Info

Sunrise of Minnetonka
18605 Old Excelsior Boulevard
Minnetonka, MN 55345
Hennepin County
Parcel:

Phone:

License Info

License: HFID 24010

Risk:
License:
Expires on:
CFPM: Chantal Avarado
CFPM #: 52999; Exp: 6/14/2027

Inspection Info

Report Number: F8041251045
Inspection Type: Full - Single
Date: 6/24/2025 Time: 10:00 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 2
Total Priority 2 Orders: 0
Total Priority 3 Orders: 4
Delivery: Emailed

New Order: 2-100 Supervision
2-102.12DMN *Priority Level: Priority 3 CFP#: 2*
MN Rule 4626.0033D Post the certified food protection manager certificate.
COMMENT: CERTIFIED FOOD PROTECTION MANAGER CERTIFICATE NOT POSTED ON SITE.
Comply By: 7/1/2025 Originally Issued On: 6/24/2025

! **New Order: 4-500 Equipment Maintenance and Operation**
4-501.114C1 *Priority Level: Priority 1 CFP#: 16*
MN Rule 4626.0805C1 Provide and maintain an approved chlorine chemical sanitizer solution that has a minimum concentration of 50 ppm and a minimum temperature of 75 degrees F (24 degrees C) for water with a pH of 8 or less or a minimum temperature of 100 degrees F (38 degrees C) for water with a pH of 8.1 to 10.
COMMENT: ISSUED 6/28/23 (REPEAT 6/24/25): DISH MACHINE IN MEMORY CARE DISPENSING 0 PPM CHLORINE SANITIZER SOLUTION. ESTABLISHMENT WILL CONTACT CHEMICAL REP. TO SERVICE. DISCONTINUE USE UNTIL MACHINE IS DISPENSING AT LEAST 50 PPM CHLORINE.
Comply By: 6/24/2025 Originally Issued On: 6/24/2025

! **New Order: 4-500 Equipment Maintenance and Operation**
4-501.114D *Priority Level: Priority 1 CFP#: 16*
MN Rule 4626.0805D Provide and maintain an approved other solution of a chemical that achieves sanitization as defined in 4626.0020 subpart 75.
COMMENT: LACTIC ACID SANITIZER SOLUTION CONCENTRATION AT THE THREE COMPARTMENT SINK MEASURED 0 PPM. SOLUTION CONTAINER WAS ALMOST EMPTY. ESTABLISHMENT IS IN THE PROCESS OF SWITCHING CHEMICAL SUPPLIERS AND NEW COMPANY IS EXPECTED TO ARRIVE SOON TO INSTALL NEW CHEMICALS. FACILITY WILL USE BLEACH AT THE THREE COMP. SINK UNTIL NEW CHEMICALS ARE INSTALLED.
Comply By: 6/24/2025 Originally Issued On: 6/24/2025

New Order: 4-600 Cleaning Equipment and Utensils
4-601.11C *Priority Level: Priority 3 CFP#: 49*
MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.
COMMENT: BUILD-UP OF FOOD AND DEBRIS ON THE TABLE MOUNTED CAN OPENER HANDLE/HOLDER.
Comply By: 6/25/2025 Originally Issued On: 6/24/2025

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.11 *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1515 Maintain the physical facilities in good repair.
COMMENT: THE FAUCET AT THE BEVERAGE AREA FOOD PREP SINK IS LEAKING.
Comply By: 7/1/2025 Originally Issued On: 6/24/2025

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.12A *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1520A Clean and maintain all physical facilities clean.
COMMENT: 1. ACCUMULATION OF DUST AROUND THE CEILING VENTS IN THE KITCHEN. 2. MOLD ON WALL WHERE THE DIRTY SIDE OF THE DISH TABLE IS SEALED.
Comply By: 7/1/2025 Originally Issued On: 6/24/2025

Food & Beverage General Comment

Inspection was completed with Culinary Director, Dave Dohanick. Joey Keen was the lead Health Regulation Division Nurse Evaluator.

This establishment has a commercial kitchen on the main floor and a serving kitchen in memory care. There is also a bistro area near the entry that has coffee and water available for residents/guests.

Discussed the following:
-Employee illness policy and logging requirements
-Handwashing
-Glove-use and bare hand contact
-Proper food storage
-Date marking
-Vomit clean-up procedures
-Restrictions concerning serving a highly susceptible population

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

I acknowledge receipt of the Metro District Office inspection report number F8041251045 from 6/24/2025

Dave Dohanick
Culinary Director

Sarah Conboy,
Public Health Sanitarian Supervisor
651-201-3984
sarah.conboy@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Establishment Info

Sunrise of Minnetonka
Minnetonka
County/Group: Hennepin County

Inspection Info

Report Number: F8041251045
Inspection Type: Full
Date: 6/24/2025
Time: 10:00 AM

Equipment Temperature: Product/Item/Unit: cottage cheese**; Temperature Process:** Cold-Holding
Location: upright cooler at 36 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: ham**; Temperature Process:** Cold-Holding
Location: line cooler at 37 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: sliced tomato**; Temperature Process:** 37
Location: line cooler at 37 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: cut melon**; Temperature Process:** Cold-Holding
Location: walk-in cooler at 36 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: white bean soup**; Temperature Process:** Cold-Holding
Location: walk-in cooler at 36 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: sour cream**; Temperature Process:** Cold-Holding
Location: Memory Care reach-in cooler at 37 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: milk**; Temperature Process:** Cold-Holding
Location: Memory care upright cooler at 38 Degrees F.
Comment:
Violation Issued?: No

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Sanitizer Observations/Recordings

Establishment Info

Sunrise of Minnetonka
Minnetonka
County/Group: Hennepin County

Inspection Info

Report Number: F8041251045
Inspection Type: Full
Date: 6/24/2025
Time: 10:00 AM

Sanitizing Chemical: **Product:** Lactic Acid**; Sanitizing Process:** 3-Compartment Sink
Location: 3-Comp Sink **Equal To** 0 PPM
Comment:
Violation Issued?: Yes

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Dish Machine
Location: Memory Care **Equal To** 0 PPM
Comment:
Violation Issued?: Yes

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 168 Degrees F.
Comment:
Violation Issued?: No