Electronically Delivered

October 19, 2023

Licensee
Sunset Homes Assisted Living
9938 18th Avenue Northwest
Oronoco, MN 55960

RE: Project Number(s) SL36995015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 4, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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.

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

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

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH also may

impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $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 the MDH within 15 calendar days of the correction order receipt date.

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

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

Please address your cover letter for reconsideration requests to:

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

REQUESTING A HEARING

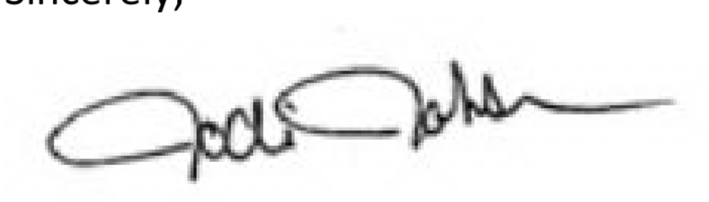
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

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

If you have any questions, please contact me.

Sincerely,



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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36995	A. BUILDING: _____ B. WING _____	10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOMES ASSISTED LIVING	9938 18TH AVENUE NW ORONOCO, MN 55960

(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: SL36995015-0 On October 2, 2023, through October 4, 2023, 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 four active residents; four receiving services under the Assisted Living license.	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 License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated October 4, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in	0 510		

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0 510	Continued From page 2 assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical, and nursing standards for infection control by one of one employee (unlicensed personnel (ULP)-B). This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 3, 2023, at 8:21 a.m., the surveyor observed ULP-B without sanitizing or washing hands put on gloves and enter R1's bathroom. ULP-B was observed to be cleaning R1's toilet and wiping down surfaces. On October 3, 2023, at 8:37 a.m. the house phone was ringing, and ULP-B came out of R1's bathroom and answered the phone while wearing the same gloved hands. ULP-B then hung up the phone, walked back to R1's room, knocked on her door and verbally reminded R1 she had an appointment. Wearing the same gloves, ULP-B returned to R1's bathroom and continued to clean bathroom surfaces.	0 510		

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0 510	Continued From page 3 On October 3, 2023, at 8:40 a.m. ULP-B stated he should have removed his gloves and washed his hand prior to answering the phone stating, "my error". ULP-B further stated he had been cleaning the toilet and other contaminated surfaces while wearing the gloves. On October 3, 2023, at 9:35 a.m. clinical nurse supervisor/licensed assisted living director/owner (CNS/LALD/O)-A stated ULP-B should have removed his gloves and washed hands prior to answering the phone. CNS/LALD/O-A stated hand hygiene should be performed before and after glove use "it's as simple as that". The licensee's undated, Infection Control Program policy noted [The Licensee] had and maintains an infection control program that complies with accepted health care, medical and nursing standards for infection control. [The Licensee's] program is consistent with the CDC (Centers for Disease Control) guidelines for infection prevention and control in long-term-care facilities. The licensee's Hand Hygiene policy revised September 22, 2023, noted use of gloves does not replace hand washing. Hands should be washed, or decontaminated: c. after contact with environmental surfaces or equipment in the immediate vicinity of the resident. The licensees' Procedure for Using Gloves policy dated January 5, 2022, noted gloves are to be worn whenever there may be direct contact between caregiver's hands and blood, body fluids, secretions, feces, or a contaminated item. 1. Wash hands	0 510		

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0 510	Continued From page 4 2 Apply gloves to both hands 3. Complete tasks 4. Place any contaminated materials in proper receptacle 5. Remove gloves 6. Dispose of used gloves in proper receptacle 7. Rewash hands. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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.	0 680		

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0 680	Continued From page 5 (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post emergency exit diagrams on each floor. In addition, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During a tour of the facility on October 2, 2023, at 12:40 p.m., the surveyor observed no emergency exit diagrams in the hallways of the basement floor of the licensee's building. On October 3, 2023, at 9:45 a.m. the surveyor reviewed the emergency preparedness plan with clinical nurse supervisor/licensed assisted living director/owner (CNS/LALD/O)-A. The licensee's EP plan consisted of several documents and policies dated September 22, 2023. The plan included a hazard and vulnerability assessment and various policies/procedures. The licensee's plan lacked the following required	0 680		

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0 680	Continued From page 6 content: - Emergency prep testing requirements On October 3, 2023, at 9:45 a.m. clinical nurse supervisor/licensed assisted living director/owner (CNS/LALD/O)-A stated he had not completed a tabletop or full-scale exercise in the last year and the licensee lacked the above requirement. CNS/LALD/O-A indicated he had misunderstood the requirement. On October 3, 2023, at 10:00 a.m. CNS/LALD/O-A stated there was no emergency exit posting on each floor as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 790 SS=E	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by:	0 790		

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0 790	Continued From page 7 Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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). Findings include: On October 2, 2023, survey staff toured the facility with the clinical nurse supervisor/licensed assisted living director/owner (CNS/LALD/O)-A. During the facility tour, survey staff observed the following: 1. A portable fire extinguisher was stored on the kitchen counter. Fire extinguishers must be properly mounted to prevent them from being moved or damaged. 2. Fire extinguisher tags had monthly inspections recorded on 7/1/23 and 9/7/23. Fire extinguisher inspections must be completed every month to ensure that each extinguisher is in its designated place, that it has not been tampered with, and that there is no obvious physical damage or condition that would interfere with its use or operation. These deficient conditions were verified by the CNS/LALD/O-A during an interview with survey staff on October 6, 2023, at approximately 10:00 a.m.	0 790		

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0 790	Continued From page 8 TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On October 2, 2023, survey staff toured the facility with the clinical nurse supervisor/licensed	0 800		

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0 800	Continued From page 9 assisted living director/owner (CNS/LALD/O)-A. During the facility tour, survey staff observed the following: 1. Both panes of a window were foggy in resident room 4. The CNS/LALD/O-A explained that the window seals were bad and that this window required repair. 2. In resident room 2, there was a hole in the wall. The CNS/LALD/O-A explained that the resident living in this room punched the hole in this wall a few days ago. These deficient conditions were verified by the CNS/LALD/O-A during an interview with survey staff on October 6, 2023, at approximately 10:00 a.m. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in	01620		

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01620	Continued From page 10 the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a reassessment not to exceed 90 days for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's Service Plan (Private) - Addendum to Contract dated October 4, 2023, indicated R1 received services including activity assist, appointment reminders, medication assistance, bathing, behavior monitoring, grooming, housekeeping and laundry assist. R1's last two assessments dated June 21, 2023, and September 20, 2023, were provided. 91 days had passed between assessments (one day late).	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36995	A. BUILDING: _____ B. WING _____	10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOMES ASSISTED LIVING	9938 18TH AVENUE NW ORONOCO, MN 55960

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01620	Continued From page 11 On October 4, 2023, at 8:05 a.m. clinical nurse supervisor/licensed assisted living director/owner (CNS/LALD/O)-A stated R1's last quarterly assessment was conducted after the 90-day requirement. CNS/LALD/O-A stated their computer system had a tracking mechanism, but a family emergency had taken place and the assessment could not be completed on the due date. The licensee's Initial and On-Going Nursing Assessment of Residents policy dated revised September 22, 2023, identified on-going assessments would not exceed 90-day from the last date of the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.	01640		

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	36995	A. BUILDING: _____ B. WING _____	10/04/2023

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01640	Continued From page 12 (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for one of one resident (R1). In addition, the licensee failed to include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included bipolar disorder (a mental health condition that causes extreme mood swings that include emotional highs and lows) and schizoaffective disorder (a mental disorder characterized by abnormal thought processes and an unstable mood). R1's Service Plan (Private) - Addendum to	01640		

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01640	Continued From page 13 Contract dated October 4, 2023, indicated R1 received services including activity assist, appointment reminder, medication assistance, bathing, behavior monitoring, grooming, housekeeping, and laundry assist. R1's Service Chart documentation form dated October 1, 2023, through October 2, 2023, included staff initials for completing the task of grooming: assist client with grooming to prepare for the day, shaving, hair care, skin care, oral care. On October 3, 2023, at 8:21 a.m. unlicensed personnel (ULP)-B stated R1 was independent with dressing and grooming. ULP-B further stated R1 only needed help with medications and housekeeping tasks. On October 4, 2023, at 8:26 a.m., clinical nurse supervisor/licensed assisted living director/owner (CNS/LALD/O)-A stated the current services reflected on R1's service plan was not correct. CNS/LALD/O-A stated R1 was independent with grooming needs and was unsure why this task had generated to the service plan or the service chart documentation form indicating the service plan should have been revised. In addition, CNS/LALD/O-A stated he was unable to locate the signed service plan agreement for R1. The licensee's Development and Revision of the Service Plan policy revised on September 20, 2023, indicated in the event a client changes condition, requires reassessment for more services, or is determined to have changes in the care needs, the client's service plan needs modification. The RN will make necessary changes to the service plan, sign the revised service plan, and request that the client and/or	01640		

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01640	Continued From page 14 client's representative sign and date the revised service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address:	01790		

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01790	Continued From page 15 (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) trained and ensured competency for one of one employee (unlicensed personnel (ULP)-B) providing medications for residents with unplanned time away from home when the licensed nurse was not available.	01790		

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01790	Continued From page 16 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 included: ULP-B was hired on September 24, 2021, to provide direct care services to residents of the facility. ULP-B's employee record lacked documentation of competencies for providing medications to residents with medication management who have unplanned time away from home. On October 3, 2023, at 2:15 p.m., clinical nurse supervisor/licensed assisted living director/owner (CNS/LALD/O)-A stated ULP-B's employee record did not include evidence of the above training or competency. CNS/LALD/O-A stated he trained ULP-B but did not document training or competency in the above. CNS/LALD/O-A further stated none of the licensee's current employees would have documented training or competence in the above skill. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01790		

Minnesota Department of Health
Food Pools and Lodging Services Section
625 Robert St N
St. Paul
651-201-4500

Type: Full
Date: *10/04/23*
Time: 15:33:40
Report: 7962231146

Food and Beverage Establishment Inspection Report

Location:
Sunset Homes Assisted Living
3686 Kenosha Drive Nw
Rochester, MN55902
Olmsted County, 55

Establishment Info:
ID #: 0038487
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5073228055
ID #:

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

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

3-501.16A1 ***** Priority 1 *****

MN Rule 4626.0395A1 Maintain all hot, TCS foods at 135 degrees F (57 degrees C) or above. Roasts may be held at 130 degrees F (54 degrees C) or above if cooked or reheated in accordance with the specified time and temperature requirements in 4626.0340B.

130DF PAN OF BEEF TACOS IN OVEN TO KEEP WARM FOR CLIENTS WHO, WENT TO THE STORE, MISSED LUNCH, AND WILL BE RETURNING SOON PER STAFF, OVEN TURNED ON TO WARM TO KEEP LUNCH HOLDING AT 135DF OR HIGHER

Corrected on Site

5-200B Plumbing: cross connections

5-203.14A ***** Priority 1 *****

MN Rule 4626.1085A Water used under pressure in equipment in food and beverage establishments must be drained to a sanitary sewer through an air gap. Examples: refrigeration cooling water, water softener, and drained steam jacketed kettles.

WATER SOFTENER DISCHARGE LINES DO NOT FOLLOW MN PLUMBING CODE REQUIREMENTS, FACT SHEET OF CORRECT INSTALLATION SENT WITH REPORT

Comply By: 10/11/23

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

NO HAND WASH SIGN AT DESIGNATED HAND WASH BASIN OF TWO COMPARTMENT SINK

Type: Full
Date: *10/04/23*
Time: 15:33:40
Report: 7962231146
Sunset Homes Assisted Living

Food and Beverage Establishment Inspection Report

OR IN BATHROOM, SENT LINK TO MDH PRINTABLE HAND WASH SIGNS
Comply By: 10/11/23

Food and Equipment Temperatures

Process/Item: Domestic Refrigerator
Temperature: 41 Degrees Fahrenheit - Location: lunch: plate of vegetarian tacos for client who went to the store, missed lunch, and will be returning soon per staff
Violation Issued: No

Process/Item: Hot Holding
Temperature: 130 Degrees Fahrenheit - Location: lunch: pan of beef tacos in oven to keep warm for clients who, went to the store, missed lunch, and will be returning soon per staff , oven turned on to warm to keep lunch holding at 135df or higher
Violation Issued: Yes

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

Establishment Info:
Email Reports to:
Owner, josepham@sunsethomesliving.com

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 7962231146 of 10/04/23.

Certified Food Protection Manager: Amber Lattimer

Certification Number: FM111917 Expires: 06/14/24

Inspection report reviewed with person in charge and emailed.

Signed: _____

Alexsis
Head of House

Signed: Heather Flueger

Heather Flueger
Public Health Sanitarian
Rochester District Office
507-208-3096
heather.flueger@state.mn.us