Electronically Delivered

January 21, 2026

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

RE: Project Number(s) SL21787016

Dear Licensee:

On December 29, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on October 24, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the October 24, 2025 survey.

The Department of Health 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.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on October 24, 2025, found not corrected at the time of the December 29, 2025, follow-up survey and/or subject to penalty assessment are as follows:

1290-Background Studies Required-144g.60 Subdivision 1 - $500.00

The details of the violations noted at the time of this follow-up survey completed on December 29, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

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;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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.

We urge you to review these orders carefully. If you have questions, please contact Jess Schoenecker at 651-201-3789.

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

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21787	A. BUILDING: _____ B. WING _____	R 12/29/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL21787016-1 On December 29, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on October 24, 2025. Ate the time of the survey, there were 63 residents; 63 receiving services under the Assisted Living with Dementia Care license. As a result of the follow-up survey, the following orders were issued and/or reissued.	{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.	
{0 420} SS=F	144G.40 Subdivision 1 Responsibility for housing and services	{0 420}		

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{0 420}	Continued From page 1 The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced by:	{0 420}	Not evaluated this survey	
{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 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	{0 480}		

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{0 480}	Continued From page 2 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:	{0 480}	Not evaluated this survey	
{0 630} SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each	{0 630}		

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{0 630}	Continued From page 3 vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by:	{0 630}	Not evaluated this survey	
{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	{0 680}		

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{0 680}	Continued From page 4 allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	{0 680}	Not evaluated this survey	
{0 730} SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care	{0 730}		

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{0 730}	Continued From page 5 professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by:	{0 730}	Not evaluated this survey	
{0 775} SS=F	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:	{0 775}	Not evaluated this survey	
{0 910} SS=B	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility.	{0 910}		

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{0 910}	Continued From page 6 (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by:	{0 910}	Not evaluated this survey	
{01060} SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to	{01060}		

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{01060}	Continued From page 7 provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by:	{01060}		
{01290} SS=D	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	{01290}	Not evaluated this survey	

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{01290}	Continued From page 8 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 interview and record review, the licensee failed to ensure employees had a cleared Department of Human Services (DHS) background study, affiliated with the current health facility identification (HFID), prior to staff providing services for one of one employee (cook (C)-N). 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: C-N was hired on July 17, 2025. On December 29, 2025, at 8:30 a.m., the surveyor requested and was provided with a NETStudy 2.0 roster dated December 29, 2025, for employees affiliated with the licensee. The roster did not identify C-N as affiliated with the licensee's HFID. C-N's employee record included a DHS Background Study Clearance dated January 4, 2024, indicating affiliation to another licensee	{01290}		

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{01290}	Continued From page 9 owned by the same owner. C-N's background study lacked affiliation with the licensee. On December 29, 2025, at 4:18 p.m., business office coordinator (BOC)-K stated they were responsible for maintaining background studies. BOC-K stated they were not aware that C-N's background study was affiliated with another licensee owned by the same owner and would run a new background study for C-N. The licensee's New Team Member Onboarding policy dated May 31, 2019, indicated new employees would pass a criminal background check prior to their first day of employment. No further information was provided.	{01290}		
{01330} SS=F	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner.	{01330}		

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{01330}	Continued From page 10 This MN Requirement is not met as evidenced by:	{01330}		
{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 by:	{01440}	Not evaluated this survey	
{01470} SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following	{01470}		

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{01470}	Continued From page 11 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), 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	{01470}		

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	21787	A. BUILDING: _____ B. WING _____	R 12/29/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{01470}	Continued From page 12 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:	{01470}	Not evaluated this survey	
{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	{01500}		

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{01500}	Continued From page 13 techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication	{01500}		

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{01500}	Continued From page 14 access in real time, and closed captions. This MN Requirement is not met as evidenced by:	{01500}	Not evaluated this survey	
{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:	{01540}	Not evaluated this survey	
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	{01620}		

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{01620}	Continued From page 15 (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 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	{01620}		

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{01620}	Continued From page 16 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 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:	{01620}		
{01640} SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (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. (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	{01640}	Not evaluated this survey	

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{01640}	Continued From page 17 the current written service plan. This MN Requirement is not met as evidenced by:	{01640}	Not evaluated this survey	
{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: (i) the type of container or containers to be used for the medications appropriate to the provider's	{01790}		

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{01790}	Continued From page 18 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:	{01790}	Not evaluated this survey	
{01890} SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the	{01890}		

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{01890}	Continued From page 19 expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by:	{01890}	Not evaluated this survey	
{01910} SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by:	{01910}	Not evaluated this survey	
{02310} SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted	{02310}		

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{02310}	Continued From page 20 living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by:	{02310}	Not evaluated this survey	

Electronically Delivered

December 8, 2025

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

RE: Project Number(s) SL21787016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 24, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, 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 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,500.00**. 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

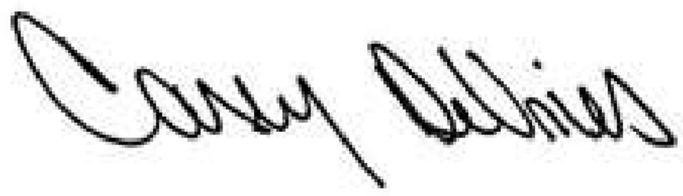
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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: SL21787016-0 On October 20, 2025, through October 24, 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 72 residents: 49 receiving services under the Assisted Living with Dementia Care license. An immediate correction order was identified on October 20, 2025, issued for SL21787016-0, 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 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.	
0 420 SS=F	144G.40 Subdivision 1 Responsibility for housing and services	0 420		

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0 420	Continued From page 1 The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide sufficient management, control, and operation of the housing and services provided by the facility. 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee had an assisted living license, effective July 1, 2025. The licensee's (renewal) "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified an affirmative checkmark next to the statement, "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and	0 420		

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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
0 420	Continued From page 2 Minnesota Rules, chapter 4659, governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." Another checkmark was noted at the statement, "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." Page five was electronically signed by the authorized agent on June 26, 2025. As a result of this survey, the following orders were issued under 0480, 0630, 0680, 0730, 0775, 0910, 1060, 1290, 1330, 1440, 1470, 1500, 1540, 1620, 1640, 1790, 1890, 1910, and 2310, which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 420		
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	0 480		

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	21787	A. BUILDING: _____ B. WING _____	10/24/2025

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0 480	Continued From page 3 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 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;	0 480		

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0 480	Continued From page 4 (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. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 20, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		

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0 630	Continued From page 5	0 630		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: R2 admitted to the licensee on May 28, 2024, with diagnoses that included Parkinson's disease, edema, anxiety disorder, breast cancer,	0 630		

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0 630	Continued From page 6 hypotension, chronic pain, constipation, and edema. R2's unsigned undated Service Plan, indicated R2 received services for transfer, mobility, toileting, bathing, dressing, personal care, and hygiene. R2's assessment entitled MN 3.0 SEHA-V 10 completed July 1, 2024, contained the following section with focus on IAPP on page 20 of the 21-page change in condition assessment: "Focus: Individualized Abuse Prevention Plan Goal: Safety will be maintained through the implementation of my individualized abuse prevention plan through the next review date Intervention: Observe and report any of the following signs of potential vulnerability, abuse or neglect. Summary of Requirements A. The Vulnerable Adult Act requires home care providers to 1) assess each resident to identify any areas of vulnerability or potential risk they pose to other vulnerable adults and 2) develop an abuse prevention plan for each resident that addresses those identified issues B. The abuse prevention plan must include the specific measures to be taken to minimize the risk of maltreatment of a vulnerable resident or to minimize the risk the resident poses to other vulnerable adults C. The nurse's assessment of a resident's areas of vulnerability or potential risk to other vulnerable adults may be documented in a separate form such as this, or documentation may be incorporated into the form used for the general nursing assessment. D. However this assessment is conducted or documented, the abuse prevention plan (i.e.,	0 630		

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0 630	Continued From page 7 identified interventions that are needed} that is based on the assessment should be incorporated into the resident's care plan and should be reflected in assignment sheets or other documents used to direct staff as they are providing services to the resident." The assessment section listed a summary of the requirement for the IAPP. The assessment section did not indicate whether R2 was at risk for abuse by others and/or at risk for abusing other vulnerable adults. On October 21, 2025, at 3:10 p.m., registered nurse (RN)-J stated the IAPP was part of a resident's assessment. RN-J stated if residents were not at risk for abuse the system did not show the IAPP on the assessment. On October 23, 2025, at 11: 45a.m, RN-J stated I have never done the IAPP at the licensee's facility, "I do not remember what the contents of the IAPP are, I do not know, if there is abuse, we know to report it". On October 23, 2025, at 12: 45p.m, clinical nurse supervisor (CNS)-C stated the IAPP was part of the old assessment entitled SEHA and stated they just switched to a new assessment tool entitled Resident Evaluation and the IAPP did not transfer over. CNS-C stated they did not remember the content requirements of the IAPP and stated, "it [referring to the system/assessment tool] gives us the questions and it would trigger, I cannot list them off the top off my head". On October 23, 2025, at 2: 40p.m, RN-J stated the IAPP was included in the new assessment tool, but they were not aware the IAPP was	0 630		

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0 630	Continued From page 8 missing, and they did not know how to add the IAPP in. RN-J stated they just learned how to add the IAPP into the new tool by their corporate office. The Licensee's undated Abuse, Neglect & Exploitation- Prevention, Reporting and Investigation policy read "Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
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;	0 680		

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0 680	Continued From page 9 (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content and failed to post an emergency preparedness plan prominently. This had the potential to affect all residents under the assisted living license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's EPP last updated January 1, 2025,	0 680		

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0 680	Continued From page 10 lacked evidence of the following required content: - missing resident policy; and - medical document policy. On October 24, 2025, at 12:38 p.m., licensed assisted living director (LALD)-D stated the EPP was posted in the copier room and a master copy was placed in their office. LALD-D stated the copier room, and their office were locked; all staff had master key to the copier room. LALD-D stated the room was not accessible to visitors or volunteers; staff would have to let them in. LALD-D stated they did not know why the above-mentioned topics were missing from the EPP. The licensee's Emergency Management Policy dated January 1, 2025, indicated the licensee shall maintain an Emergency Plan describing our all-hazards approach to emergency management. The Emergency Plan guidelines will be developed and made widely available to all staff. This plan will be maintained in accordance to state and federal guidelines will be reviewed and updated annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of	0 730		

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0 730	Continued From page 11 the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or	0 730		

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0 730	Continued From page 12 status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a discharge summary with required content for two of two residents (R9, R14) discharged from the licensee. 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: R9 R9 was admitted to the licensee on September 24, 2025, and discharged from the licensee on October 11, 2025. R9's service plan dated September 24, 2025, indicated R9 received assistance with medication administration, mobility, transferring, and toileting. R9's record lacked a discharge summary with the following required information: - a summary of the resident's stay that includes diagnoses, courses of illnesses, allergies, treatments and therapies, and pertinent lab, radiology, and consultation results; - a final summary of the resident's status from the latest assessment or review under Minnesota Statutes, section 144G.70, if applicable, that includes the resident status, including baseline	0 730		

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0 730	Continued From page 13 and current mental, behavioral, and functional status; - a reconciliation of all predischarge medications with the resident's post discharge prescribed and over-the-counter medications; and - a post discharge plan that is developed with the resident and, with the resident's consent, the resident's representatives, which will help the resident adjust to a new living environment. The post discharge plan must indicate where the resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any post discharge medical and nonmedical services the resident will need. R14 R14 was admitted to the licensee on February 24, 2025, and discharged on September 29, 2025. R14's undated and unsigned service plan indicated R14 received assistance with medication administration. R14's record lacked a discharge summary with the following required information: - a summary of the resident's stay that includes diagnoses, courses of illnesses, allergies, treatments and therapies, and pertinent lab, radiology, and consultation results; - a final summary of the resident's status from the latest assessment or review under Minnesota Statutes, section 144G.70, if applicable, that includes the resident status, including baseline and current mental, behavioral, and functional status; - a reconciliation of all predischarge medications with the resident's post discharge prescribed and over-the-counter medications; and - a post discharge plan that is developed with the resident and, with the resident's consent, the	0 730		

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0 730	Continued From page 14 resident's representatives, which will help the resident adjust to a new living environment. The post discharge plan must indicate where the resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any post discharge medical and nonmedical services the resident will need. On October 23, 2025, at 12:35 p.m., clinical nurse supervisor (CNS)-C stated they did not complete a discharge summary for R9. CNS-C stated R9 was sent to the hospital and then family contacted facility to let them know R9 was not coming back to the licensee's facility and that R9 was going to a different facility. CNS-C stated their expectation was that the RNs were supposed to complete the discharge summary report. On October 24, 2025, at approximately 12:15 p.m., registered nurse (RN)-J stated R14 was sent to the hospital for fall on September 10, 2025, and had surgery at the hospital. RN-J stated R14 was then sent to transitional care unit (TCU) and passed away at the TCU. RN-J stated they did not do the discharge summary for R14 because R14 was not discharged from their facility; R14 passed away while they were at the TCU. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the	0 775		

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0 775	Continued From page 15 State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the Minnesota State Fire Code (MSFC) in Minnesota Rules, chapter 7511. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On a facility tour on October 21, 2025, from 9:15 a.m. to 10:45 a.m., with regional care coordinator (RCC)-G and maintenance (M)-F, the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: EXIT DOOR LOCKING ARRANGEMENTS There was a controlled egress locking system installed on the emergency exit doors leading to the exterior exit path throughout the memory care unit and first floor of this facility. The controlled egress door locking system was not provided with the required device capable of deactivating the delayed egress door hardware to	0 775		

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0 775	Continued From page 16 the unlocked position from the nurse station or other approved location for occupants to exit in the event of an emergency. The procedures required to operate and unlock the controlled egress locking system for occupants to exit in the event of an emergency are required to be included in the fire safety and evacuation plan employee procedures. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 910 SS=B	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for two of four residents (R3, R8). This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety)	0 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21787	A. BUILDING: _____ B. WING _____	10/24/2025

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0 910	Continued From page 17 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: R3 R3's Assisted Living Contract signed on April 4, 2025, lacked the following required content: - in a conspicuous place and manner on the contract the Health Facility Identification number (HFID) of the licensee. R8 R8's Assisted Living Contract signed on July 14, 2025, lacked the following required content: - in a conspicuous place and manner on the contract the HFID of the licensee. On October 24, 2025, at 12:58 p.m., licensed assisted living director (LALD)-D stated the legal team had revised a new form to include the HFID number and they would be using the new form in the future. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member.	01060		

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01060	Continued From page 18 An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by:	01060		

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01060	Continued From page 19 Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation for one of one resident (R10). 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: R10 was admitted to the licensee on February 2, 2023, with diagnoses including anxiety, dementia, hypertension, and type two diabetes. R10's service plan dated February 8, 2024, indicated R10 received assistance with meal preparation and medication administration. R10's progress notes written on October 5, 2025, by registered nurse (RN)-J indicated R10 was sent to the emergency room due to a fall. R10's progress notes dated October 18, 2025, written by RN-J indicated R10 was discharged from the hospital and was sent to a transitional care unit (TCU) on October 18, 2025. R10's record lacked evidence a written notice was provided that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider;	01060		

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01060	Continued From page 20 - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal; and - a notice to the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. On October 24, 2025, at 12:16 p.m., registered nurse (RN)-J stated they were not aware of the requirement to provide a written notice with required contents for an emergency relocation or the requirement to notify the ombudsman if resident stayed out of the facility for more than four days. On October 23, 2025, at 12:34 p.m., clinical nurse supervisor (CNS)-C stated they did not provide the emergency relocation form to R10. CNS-C also stated they had not notified the ombudsman about R10's relocation. CNS-C stated they were not aware of the requirement to provide a written notice with required contents for an emergency relocation or the requirement to notify the ombudsman if a resident was emergency relocated for more than four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		

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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 interview and record review, the licensee failed to ensure a background study (BGS) was submitted and received in affiliation with the assisted living licensee for two of 68 employees (unlicensed personnel (ULP)-A), registered nurse (RN)-E). This resulted in an immediate order for correction on October 20, 2025. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), 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).	01290		

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01290	Continued From page 22 The findings include: ULP-A ULP-A was hired on May 14, 2024, to provide direct cares and services to residents. The licensee's NETStudy 2.0 (web-based system used to submit background study requests to the Department of Human Services (DHS)) roster did not include ULP-A in the list of employees whose BGS were affiliated to the licensee's healthcare facility identification (HFID) 21787. A screenshot taken from the DHS website on October 20, 2025, at 2:44 p.m., indicated ULP-A was separated from the licensee's HFID 21787 on October 3, 2025. R1's Documentation Survey Report V2 for the month of October 3, 11, 17, 2025, indicated ULP-A assisted R1 with activities of daily living during morning shift from 6:00 a.m., to 2:00 p.m. RN-E RN-E was hired on November 10, 2023, to provide oversight to ULPs and to provide direct cares and services to residents. The licensee's NETStudy 2.0 roster did not include RN-E in the list of employees whose BGS were affiliated to the licensee's HFID 21787. A screenshot taken from the Minnesota Board of Nursing (BON) Credential Search website on October 20, 2025, at 3:00 p.m., indicated RN-E was licensed as a registered nurse on March 15, 2016. A screenshot taken from the NETStudy 2.0 website on October 20, 2025, at 3:00 p.m.,	01290		

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01290	Continued From page 23 indicated RN-E was not affiliated to the licensee's HFID 21787. On October 20, 2025, at 2:00 p.m., licensed assisted living director (LALD)-D stated they were not aware they had to run a BGS for RNs who were licensed prior to year 2018. On October 20, 2025, at 3:15 p.m., LALD-D stated they did not know why ULP-A was separated from the licensee's HFID. LALD-D stated ULP-A was an active employee and worked with residents independently without supervision. On October 20, 2025, at 3:33 p.m., LALD-D stated RN-E was a part time active employee who was scheduled to work every other weekend. On October 20, 2025, at approximately 3:35 p.m., the surveyor requested the licensee's Background Studies Policy. The policy was not provided by the licensee by the time the immediate correction order was issued at approximately 4:15 p.m. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
01330 SS=F	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed	01330		

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01330	Continued From page 24 in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on 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 unlicensed personnel ((ULP)-A, ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-A ULP-A was on hired on May 14, 2024, to provide direct care to residents. R1's Documentation Survey Report V2 for October 3, 11, and 17, 2025, indicated ULP-A assisted R1 with activities of daily living during	01330		

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	21787	A. BUILDING: _____ B. WING _____	10/24/2025

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01330	Continued From page 25 morning shift from 6:00 a.m., to 2:00 p.m. ULP-B ULP-B was on hired on February 19, 2024, to provide direct care to residents. R2's medication administration record (MAR) for October 2025, indicated ULP-B administered medication to R2 on October 3, 4, 7, 11, 12, 17, and 18, 2025, during evening shift at 8:00 p.m. ULP-A and ULP-B's employee record contained the following training and competency evaluations: - documentation requirements for all services provided; - basic infection control, including blood-borne pathogens; - bathing assistance; - dressing assistance; - hair care assistance; - hearing aide use and care; - nail care assistance; - oral care assistance; - assistance with eating; - basic nutrition/food safety; - clean and safe environment; - documenting observing and reporting; - personal care AL and HC; - understanding appropriate boundaries between staff and residents and the resident's family; - procedures to utilize in handling various emergency situations; - awareness of confidentiality and privacy; and - fall risk and prevention. ULP-A and ULP-B's employee record lacked the following training and competency evaluations: - reports of changes in the resident's condition	01330		

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01330	Continued From page 26 to the supervisor designated by the assisted living provider; - maintenance of a clean and safe environment; - 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 commonly used health technology equipment and assistive devices; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and - recognizing physical, emotional, cognitive, and developmental needs of the resident. On October 23, 2025, at 10:06 a.m., registered nurse (RN)-E stated they did do some of the trainings for ULPs, but they did not train the ULPs on the above missing topics. RN-E said the missing topics were not part of the training and stated, "I would say it should be added to the skills list it is not on there." On October 23, 2025, at 10:29 a.m., business office coordinator (BOC)-K stated they did not have the missing topics mentioned above completed, they were planning to cover all of the missing topics with all employees next week. The licensee's training syllabus entitled Training Requirement for Minnesota included the following required topics:	01330		

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	21787	A. BUILDING: _____ B. WING _____	10/24/2025

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01330	Continued From page 27 - observing and reporting changes; - communication; - being person centered; and - dining and mealtime assistance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01330		
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 by:	01440		

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01440	Continued From page 28 Based on 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)-A, ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-A ULP-A was on hired on May 14, 2024, to provide direct care to residents. ULP-B ULP-B was on hired on February 19, 2024, to provide direct care to residents. On October 23, 2025, at 10:17 a.m., RN-E stated they had not done 30-day supervision for any ULP, and they did not know why it was not done. On October 23, 2025, at 12:01 p.m., clinical nurse supervisor (CNS)-C stated they followed up with employees the next day after the employees started working on their own and asked them verbally if they felt comfortable, but made no observations and they did not do any formal 30-day supervision for the ULPs. On October 23, 2025, at 12:05 p.m., business	01440		

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01440	Continued From page 29 office coordinator (BOC)-K stated there was no 30-day supervision done for any employee. BOC-K stated they would get back on track. The licensee's Supervision of Licensed and Unlicensed Team Members last revised June 5, 2025, indicated the RN or appropriate Licensed Health Professional (LPH) will provide supervision of unlicensed care team members performing delegated nursing tasks and treatment or assigned therapy treatment and tasks as required by state regulation/nurse practice act. Direct supervision of unlicensed care team members providing delegated nursing tasks, therapy tasks, or treatments will be conducted after training and competency evaluations are completed within the timeframes required by state regulation. The direct supervision of team members performing delegated tasks will be provided within 30 calendar days after the date on which the individual begins working for the community and first performs the delegated tasks for residents and thereafter as needed based on performance. No further information was provided. 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	01470		

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SUNRISE OF EDINA	7128 FRANCE AVENUE SOUTH EDINA, MN 55435

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01470	Continued From page 30 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), 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,	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21787	A. BUILDING: _____ B. WING _____	10/24/2025

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

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01470	Continued From page 31 isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff completed an orientation to assisted living facility licensing requirements and regulations before providing services for three of three employees (unlicensed personnel (ULP)-A, ULP-B, registered nurse (RN)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-A ULP-A was hired on May 14, 2024, to provide direct care to residents. ULP-A's employee record included a training record with the following topics: - an overview of Minnesota Statute chapter	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21787	A. BUILDING: _____ B. WING _____	10/24/2025

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01470	Continued From page 32 144G.08 to 144G.95, completed May 14, 2024; - assisted living bill of rights, completed May 14, 2024; and - abuse and neglect prevention, completed December 3, 2024. ULP-A's employee record lacked evidence of orientation to assisted living regulations for the following topics: - handling of emergencies and use of emergency services; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; and - 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. ULP-B ULP-B was on hired on February 19, 2024, to provide direct care to residents. ULP-B's employee record included a training record with the following topics: - an overview of Minnesota Statute chapter 144G.08 to 144G.95, completed February 20, 2024; - assisted living bill of rights, completed February 20, 2024; and - abuse and neglect prevention, completed January 30, 2025.	01470		

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	21787	A. BUILDING: _____ B. WING _____	10/24/2025

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

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01470	Continued From page 33 ULP-B's employee records lacked evidence of orientation to assisted living regulations for the following topics: - handling of emergencies and use of emergency services; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; and - 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. RN-E RN-E was hired on November 10, 2023, to provide oversight to ULPs and to provide direct cares and services to residents. RN-E's employee record included a training record with the following topics: - an overview of Minnesota Statute chapter 144G.08 to 144G.95, completed November 15, 2023; - assisted living bill of rights, completed November 15, 2023; and - abuse and neglect prevention, completed November 15, 2023. RN-E's employee records lacked evidence of orientation to assisted living regulations for the following topics: - handling of emergencies and use of emergency services;	01470		

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	21787	A. BUILDING: _____ B. WING _____	10/24/2025

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

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01470	Continued From page 34 - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; and - 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. On October 24, 2025, at 12:55 licensed assisted living director (LALD)-D stated a community introduction course including the above missing orientation topics would be given in-person going forward. LALD-D stated the previous management did not give the community introduction course. The licensee's Team Member Training policy last reviewed September 19, 2021, indicated team members will complete training required by the Minnesota Statutes Chapter 144G.63 § 1-7; 144G.64, and MN Department of Health, Rules Governing Assisted Living Facilities Chapter 4659 §4659.0190 for Minnesota Sunrise Senior Living communities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=F	144G.63 Subd. 5 Required annual training	01500		

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	21787	A. BUILDING: _____ B. WING _____	10/24/2025

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01500	Continued From page 35 (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), 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	01500		

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	21787	A. BUILDING: _____ B. WING _____	10/24/2025

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01500	Continued From page 36 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 for four of four employees (unlicensed personnel (ULP)-A, ULP-B, ULP-H and registered nurse (RN)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-A ULP-A was on hired on May 14, 2024, to provide	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21787	A. BUILDING: _____ B. WING _____	10/24/2025

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

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01500	Continued From page 37 direct care to residents. ULP-A's employee record contained a training record for the following required topics: - assisted living bill of rights, completed September 22, 2025. ULP-A's employee record lacked documentation of eight hours of annual training completed for every 12 months of employment, including the following required topics: - reporting of maltreatment of vulnerable adults; - infection control; - effective approaches to use to problem solve when working with a resident's challenging behaviors and how to communicate with residents who have dementia or related disorders; - review of provider's policies and procedures; and - principals of person-centered planning/service delivery. ULP-B ULP-B was on hired on February 19, 2024, to provide direct care to residents. ULP-B's employee record contained a training record for the following required topics: - assisted living bill of rights, completed March 17, 2025; and - infection control, completed January 30, 2025. ULP-B's employee record lacked documentation of eight hours of annual training completed for every 12 months of employment, including the following required topics: - reporting of maltreatment of vulnerable	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21787	A. BUILDING: _____ B. WING _____	10/24/2025

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

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01500	Continued From page 38 adults; - effective approaches to use to problem solve when working with a resident's challenging behaviors and how to communicate with residents who have dementia or related disorders; - review of provider's policies and procedures; and - principals of person-centered planning/service delivery. ULP-H ULP-H was on hired on July 26, 2016, to provide direct care to residents. ULP-H's employee record contained a training record for the following required topics: - assisted living bill of rights, completed April 10, 2025; and - infection control, completed March 11, 2025. ULP-H's employee records lacked documentation of eight hours of annual training completed for every 12 months employment, including the following required topics: - reporting of maltreatment of vulnerable adults; - effective approaches to use to problem solve when working with a resident's challenging behaviors and how to communicate with residents who have dementia or related disorders; - review of provider's policies and procedures; and - principals of person-centered planning/service delivery. On October 21, 2025, at approximately 8:30 a.m., the surveyor observed ULP-H perform medication administration to R11.	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21787	A. BUILDING: _____ B. WING _____	10/24/2025

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

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01500	Continued From page 39 RN-E RN-E was hired on November 10, 2023, to provide oversight to ULPs and to provide direct cares and services to residents. RN-E's employee record contained a training record for the following required topics: - assisted living bill of rights, completed September 22, 2025; and - infection control, completed January 1, 2025. RN-E's record lacked documentation of eight hours of annual training completed for every 12 months employment, including the following required topics: - reporting of maltreatment of vulnerable adults; - effective approaches to use to problem solve when working with a resident's challenging behaviors and how to communicate with residents who have dementia or related disorders; - review of provider's policies and procedures; and - principals of person-centered planning/service delivery. On October 21, 2025, at 11:51 a.m., business office coordinator (BOC)-K stated they were responsible for assigning and keeping records of training for the licensee's employees. BOC-K stated they did figure out that some of the required training topics were missing and they were planning to provide training to employees on the missing topics next week. On October 23, 2025, at 11:58 a.m., RN-J stated they did not know if they did provide annual trainings for the above-mentioned missing	01500		

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	21787	A. BUILDING: _____ B. WING _____	10/24/2025

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01500	Continued From page 40 training topics. RN-J stated the licensee had their own learning channels training program and that was what they followed. On October 23, 2025, at 12:55 p.m., licensed assisted living director (LALD)-D stated they did not know why the annual training was not given to employees and stated the previous management did not do it. The licensee's Team Member Training policy dated September 19, 2021, read, "8. Required annual training - all team members that perform direct services will complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the community or another source and will include topics relevant to the provision of assisted living services. The annual training includes: a. Reporting of maltreatment of vulnerable adults; b. Assisted living bill of rights and team member responsibilities related to ensuring the exercise and protection of those rights; c. Infection control techniques including hand washing, the need for and use of protective gloves, gowns, and masks, appropriate disposal of contaminated materials and equipment, disinfecting environmental surfaces, and reporting communicable diseases; d. 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; e. Review of the community's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21787	A. BUILDING: _____ B. WING _____	10/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01500	Continued From page 41 f. The principles of person-centered planning and service delivery and how they apply to direct support services provided by the team member; g. Dementia training as described above; and h. Annual training may also contain high quality and research -based training (may be online) on providing services to residents with hearing loss and will include one or more of the following topics: i. An explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; ii. Health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or iii. 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." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) 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	01540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21787	A. BUILDING: _____ B. WING _____	10/24/2025

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SUNRISE OF EDINA	7128 FRANCE AVENUE SOUTH EDINA, MN 55435

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01540	Continued From page 42 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 four of four employees (unlicensed personnel (ULP)-A, ULP-B, ULP-H, registered nurse (RN)-E) received at least eight hours of initial dementia care training within 80 working hours of their employment start date and two hours of annual training completed for every 12 months employment. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-A	01540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21787	A. BUILDING: _____ B. WING _____	10/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01540	Continued From page 43 ULP-A was on hired on May 14, 2024, to provide direct care to residents. ULP-A's employee record contained the following dementia and mental illness trainings: - behavioral expression- an interdisciplinary action for a total duration of one hour completed on May 30, 2025; - dementia care supporting families for a total duration of one hour completed on March 29, 2025; and - about mental illness training: common condition and disorders for a total duration of one hour completed on September 2, 2025. ULP-A's employee records lacked documentation of eight hours initial dementia training completed within 80 working hours of their employment start date and was one hour short of the required two hours of initial mental illness training. ULP-B ULP-B was hired on February 19, 2024, to provide direct care to residents. ULP-B's employee record contained the following dementia: - behavioral expression- an interdisciplinary action for a total duration of one hour completed on June 19, 2025; and - dementia care supporting families for a total duration of one hour completed on March 17, 2025. ULP-B's employee records lacked documentation of eight hours initial dementia training completed within 80 working hours of their employment start date and two hours of initial mental illness training.	01540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21787	A. BUILDING: _____ B. WING _____	10/24/2025

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

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01540	Continued From page 44 ULP-H ULP-H was hired on July 26, 2016, to provide direct care to residents. ULP-H's employee record contained the following dementia and mental illness trainings: - behavioral expression- an interdisciplinary action for a total duration of one hour completed on April 10, 2025; and - dementia care supporting families for a total duration of one hour completed on April 10, 2025; and ULP-H's employee records lacked documentation of the required initial two hours of mental illness training. On October 21, 2025, at approximately 8:30 a.m., the surveyor observed ULP-H perform medication administration to R11. RN-E RN-E was hired on November 10, 2023, to provide oversight to ULPs and to provide direct cares and services to residents. RN-E's employee record contained the following dementia and mental illness trainings: - behavioral expression for a total duration of one hour completed on May 5, 2025; - dementia care supporting families for a total duration of one hour completed on February 26, 2025; and - about mental illness training: common condition and disorders for a total duration of one hour completed on September 28, 2025. RN-E's employee records lacked documentation of eight hours initial dementia training completed within 80 working hours of their employment start	01540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21787	A. BUILDING: _____ B. WING _____	10/24/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01540	Continued From page 45 date and was one hour short of the required two hours of initial mental illness training. On October 21, 2025, at approximately 11:50 a.m., business office coordinator (BOC)-K stated they were responsible for assigning and keeping records of training for the licensee's employees. BOC-K stated they did figure out that some of the required training topics were missing and they were planning to provide training to employees on the missing topics next week. BOC-K confirmed that the above-mentioned missing topics for dementia and mental illness were missing. BOC-K stated they did not know why those trainings were missing and stated it was before they started working for the licensee. On October 23, 2025, at 10:21 a.m., RN-E stated they did not do annual training for the missing topics including dementia. RN-E stated they thought they had two hours of dementia trainings completed. On October 23, 2025, at 12:52 p.m., clinical nurse supervisor (CNS)-C stated they did not know how many hours of dementia training was required, "I do not know how many hours of dementia trainings are required for Minnesota at the top of my head, I am not the guru of MN regulations." On October 23, 2025, at 12:55 p.m., licensed assisted living director (LALD)-D stated they did not know why the annual training was not given to employees and stated the previous management did not do it. The licensee's Team Member Training dated September 19, 2021, indicated for assisted living facilities with dementia care, direct care team members will have completed at least eight hours	01540		

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	21787	A. BUILDING: _____ B. WING _____	10/24/2025

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01540	Continued From page 46 of initial training on the required dementia topics within 80 working hours of the employment start date and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter." 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 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.	01620		

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01620	Continued From page 47 (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 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) conducted ongoing resident assessment and reassessment, not to exceed 14 calendar days from the admission date and 90 calendar days from the last date of the assessment for three of three residents (R2, R3, R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	01620		

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01620	Continued From page 48 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 May 28, 2024, with diagnoses including Parkinson's disease and breast cancer. R2's unsigned undated Service Plan Report, indicated R2 received services for transfer, mobility, toileting, bathing, dressing, personal care, and hygiene. R2's record included nursing pre-admission assessment completed on May 9, 2024, 14-day assessment completed June 10, 2024, and nursing assessments completed on July 1, 2024, and July 18, 2025. The assessment completed on July 18, 2025, was 292 days past the 90-calendar day requirement. R3 R3was admitted to the licensee on April 4, 2025, with diagnoses including heart failure, hypertension, gastroesophageal reflux disease, arthropathy, and chronic obstructive pulmonary disease. R3's Service Plan Report signed October 21, 2025, indicated R3 received services for bathing assistance, laundry, dressing assistance, meal preparation, toileting assist, transfer, and mobility assistance. R3's record included nursing pre-admission assessment completed on April 3, 2025, Change in Condition Assessment completed April 24,	01620		

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01620	Continued From page 49 2025, and nursing assessments completed on September 3, 2025, and September 30, 2025. The assessment completed on April 24, 2025, was seven days past the 14-calander day requirement and the assessment completed on September 3, 2025, was 42 days past the 90-calendar day requirement. R7 R7 was admitted to the licensee on June 22, 2023, with diagnoses including osteoarthritis, depressive disorder, restless leg syndrome, insomnia, and Alzheimer's disease. R7 Service Plan Report dated June 22, 2023, indicated R7 received medication management services. R7's record included nursing pre-admission assessment completed on April 28, 2023, Change in Condition Assessment completed July 4, 2023, and nursing assessments completed on January 2, 2024, June 27, 2024, December 21, 2024, and August 21, 2025. The assessment completed on January 2, 2024, was 93 days past the 90-calendar day requirement; the assessment completed on June 27, 2024, was 87 days past the 90-calendar day requirement; the assessment completed on December 21, 2024, was 88 days past the 90-calendar day requirement; and the assessment completed on August 21, 2025, was 153 days past the 90-calendar day requirement. On October 21, 2025, at 3:00 p.m., registered nurse (RN)-J stated, they did not know why the assessments were late. RN-J stated clinical nurse supervisor (CNS)-C was responsible for completing the assessments. On October 22, 2025, at 10:50 a.m., CNS-C	01620		

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01620	Continued From page 50 stated the previous CNS was gone and the previous RN quit, and they came to support. CNS-C stated they were trying to track the assessments to bring them back to compliance. CNS-C stated they do the assessments when the system triggers them at 14 days and every 90 days. On October 23, 2025, at 11:15 a.m., RN-J stated they used to do the assessments every six months, and they started doing the assessment quarterly in March of 2025. The licensee's Assessing and evaluating Residents policy last revised on May 15, 2025, read, "2. Upon move-in the comprehensive assessment or evaluation is completed/updated per state/province regulation and includes focused assessments/evaluations such as physical, mental and cognitive needs, fall risk, skin integrity risk, pain management, assistance with dining and special dietary needs, behavior(s), safety awareness, etc. 3. A Licensed Nurse (LN)/designee in collaboration with the interdisciplinary team (IDT) shall complete a comprehensive assessment or evaluation of residents at the following times or in accordance with the requirements and timeframes of state/province regulations: a. Prior to move in. b. Upon move-in, as required by state/province regulation. c. Annually or as required by state/province regulations/law and d. Upon a significant change in condition." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01620		

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01620	Continued From page 51 (21) days	01620		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (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. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the resident or resident's designated representative and the licensee to document agreement on the services to be provided for four of five residents (R3, R4, R7, R8). This practice resulted in a level two violation (a	01640		

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01640	Continued From page 52 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: R2 R2 was admitted to the licensee on May 28, 2024, with diagnoses including anxiety disorder, Parkinson's disease, and breast cancer. R2's unsigned undated Service Plan Report indicated R2 received physical assist of one person for toileting, bathing, transferring, and laundry. R4 R4 was admitted to the licensee on September 18, 2024, with diagnoses including cerebral infarction, hypertension, anemia, depression, hyperlipidemia, constipation, and shortness of breath. R4's unsigned undated Service Plan Report indicated R4 received assistance for medication administration, safety checks, physical assist of one person for toileting, bathing, dressing, mobility, and transferring. R7 R7 was admitted to the licensee on June 22, 2023, with diagnoses including Alzheimer's disease, depressive disorder, obstructive sleep apnea, and auditory hallucination.	01640		

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01640	Continued From page 53 R7's unsigned and undated Service Plan Report indicated R7 received assistance for medication administration. R8 R8 was admitted to the licensee on July 22, 2025, with diagnoses including chronic kidney disease, type II diabetes, dysthymic disorder, and transient ischemic heart attack. R8's unsigned and undated Service Plan Report indicated R8 received assistance for medication administration. On October 22, 2025, at 10:58 a.m., clinical nurse supervisor (CNS)-C stated they were aware the service plans were supposed to be signed but they were not aware the service plans for the above-mentioned residents were not signed. CNS-C stated they did not know why the service plans were not signed. 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	01790		

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01790	Continued From page 54 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: (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;	01790		

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01790	Continued From page 55 (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) developed training and competencies for unlicensed personnel (ULP) providing medications to residents for unplanned time away from home when the licensed nurse was not available for two of two employees (unlicensed personnel (ULP)-B, ULP-H). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was on hired on February 19, 2024, to provide direct care to residents. ULP-H ULP-H was on hired on July 26, 2016, to provide direct care to residents.	01790		

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01790	Continued From page 56 ULP-B and ULP-H's employee record lacked documentation of training and a competency evaluation for unplanned time away from home. On October 21, 2025, at approximately 8:30 a.m., the surveyor observed ULP-H perform medication administration to R11. On October 23, 2025, at 9:52 a.m., ULP-H stated they did pack medications and gave them to the resident or resident representative when residents went on unplanned times away. ULP-H stated they were trained as a trained medication aide (TMA) and they were also trained on how to pass medication by the licensed practical nurse when they started working for the licensee. On October 23, 2025, at 10:06 a.m., RN-E stated they did not think the unplanned times away medication administration training was part of the licensee's training curriculum. RN-E stated it should be added to the skills checklist. On October 23, 2025, at 12:00 p.m., RN-J stated they did not do unplanned times away medication administration training with any employee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01790		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01890	Continued From page 57 label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure expired medications were disposed of for four residents (R12, R13, R15) within three of four medication carts (M1, M2 and M3). 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 October 23, 2025, at 3:17 p.m., the surveyor conducted a review of locked medication cart (M1). The surveyor observed the following in the M1 medication cart: R15 had the following expired medications: - acetaminophen 325 milligram (mg) tablet (two bubble pack cards), expired, July 2025; - trazadone 50mg 1/4 tablet expired, July 2025; and - senna 8.6 mg tablet expired, July 2025. On October 24, 2025, at 10:52 a.m., the surveyor conducted a review of locked medication carts (M2 and M3). The surveyor observed the	01890		

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01890	Continued From page 58 following in the medication carts: M2 R12 had the following expired medications: - naloxone HCL 4mg nasal spray expired September 2025; - milk of magnesia suspension, expired August 2025; and - trazadone 50mg 1/2 tablet, expired July 2025. M3 R13 had the following expired medication: - senna 8.6 mg tablet (two bubble pack cards), expired September 2025. On October 23, 2025, at 3:22 p.m., registered nurse (RN)-J stated the unlicensed personnel (ULP) were supposed to check the medication carts for expired medication. RN-J stated they were planning to do medication cart audits, but they did not get to it yet. On October 24, 2025, at 10:51 a.m., ULP-M stated they check the medication cart twice a month and ULPs were supposed to pull out expired medication and bring it to the wellness office and inform the nurse. ULP-M stated the expired medications were an oversight. The licensee's disposal of unused medication policy last revised September 3, 2021, indicated expired medications managed by the community will be disposed of using the drug disposal system. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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01910	Continued From page 59	01910		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation of disposition of medications for two of two residents (R9, R14) discharged from the licensee. 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	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21787	A. BUILDING: _____ B. WING _____	10/24/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01910	Continued From page 60 a large portion or all of the residents). The findings include: R9 R9 was admitted to the licensee on September 24, 2025, and discharged from the licensee on October 11, 2025. R9's service plan dated September 24, 2025, indicated R9 received assistance with medication administration, mobility, transferring, and toileting. R14 R14 was admitted to the licensee on February 24, 2025, and discharged on September 29, 2025. R14's undated and unsigned service plan indicated R14 received assistance with medication administration. R9 and R14's record lacked evidence of documented disposition of medications for R9 and R14 to include the name of the medication, strength, prescription number if applicable, quantity, to whom the medications were given, date of disposition, and the names of the staff and other individuals involved in the disposition. On October 23, 2025, at 12:38 p.m., registered nurse (RN)-J stated the discontinued the medications for the above-mentioned residents in the system by they did not complete the medication disposition documentation. RN-J stated, "that is my fault". No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21787	A. BUILDING: _____ B. WING _____	10/24/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for two of two residents (R2, R4) with consumer bed rails. 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 22, 2025, at 8:40 a.m., the surveyor observed a Halo bed rail on the right side of R2's hospital bed. On October 22, 2025, at 9:50 a.m., the surveyor observed a Halo bed rail on both sides of R4's hospital bed. R2 R2 was admitted to the licensee on May 28, 2024, with diagnoses including anxiety disorder,	02310		

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	21787	A. BUILDING: _____ B. WING _____	10/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 62 Parkinson's disease, and breast cancer. R2's unsigned Service Plan Report indicated R2 received physical assist of one person for toileting, bathing, transferring, and laundry. R4 R4 was admitted to the licensee on September 18, 2024, with diagnoses including cerebral infarction, hypertension, anemia, depression, hyperlipidemia, constipation, and shortness of breath. R4's unsigned Service Plan Report indicated R4 received medication administration, safety checks, physical assist of one person for toileting, bathing, dressing, mobility, and transferring. R2 and R4's record included the following: - purpose and intention of the bed rail; - description of the bed rail; - the resident's bed rail use/need assessment; - the resident's preferences; - installation and use according to manufacturer's guidelines; and - physical inspection of bed rail. R2 and R4's record lacked documentation the licensee checked the Consumer Product Safety Commission (CPSC) recall list to make sure there were no active recalls on the bed rails. R2 and R4's record also lacked documentation that risk and befit related to bed rail use was discussed with the residents. On October 23, 2025, at 11:03 a.m., registered nurse (RN)-J stated they were not aware they had to check the CPSC for consumer bed rail recalls. On October 22, 2025, at 1:19 p.m., clinical nurse	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21787	A. BUILDING: _____ B. WING _____	10/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 63 supervisor (CNS)-C stated they did not check the CPSC for consumer bed rail recalls and stated their maintenance department was responsible for checking for recalls. On October 22, 2025, at 2:25 p.m., maintenance personnel (MX)-F stated they did not check the CPSC for consumer bed rail recalls. MX-F stated "We do not check for recalls our supplier, Direct Supply, checks the recalls for all products. We strictly get our supplies from them; we do not install products from other suppliers." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) read, "The United States Consumer Product Safety Commission (CSPC) works to save lives and ensure safety by reducing the unreasonable risk of injuries and deaths associated with consumer products, such as portable bed rails. The CSPC posts information on its website related to portable bed rail recalls. Licensees should review the CSPC website regularly for updates on recalled portable bed rails. The opportune time to do this would be with the 90-day assessment due to the requirement included in the uniform assessment tool for assessing assistive devices." The licensee's Assisted Device policy last revised July 17, 2025, read, "Definitions: o Assistive Device - Any device designed or adapted to help people with physical or emotional limitation to perform actions, tasks, and activities. o For example - Halo Safety Ring, Deluxe Assist Handle (for Joerns beds), over the bed trapeze, a high/low bed, bathroom grab bars, etc. o Restrictive Devices/Mechanical Restraints - are defined as any manual method or physical or	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21787	A. BUILDING: _____ B. WING _____	10/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 64 mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily or upon request, which restricts freedom of movement or normal access to one's body. " For example - seat belt (if resident is unable to self-release) The Licensed Nurse (LN) will complete a resident assessment/evaluation in the electronic health record (eHR) which may include: a. Ability to reposition in Bed. b. Ability to transfer between positions, to and from bed or chair, to stand and toilet. c. Cognitive ability to safely and independently use an assistive device·. d. Additional assessment or evaluation as required by state/provincial regulations. Note: This assessment is within the electronic health record (eHR). 2. Prior to use of an assistive device the Resident Care Team will determine if alternative options or devices maybe implemented. a. Alternative Options may include: i. Modifying a resident's environment or routine ii. Restorative care to enhance abilities to transfer, stand and walk. iii. A padded mat iv. Visual and verbal reminders to use the call pendant for assistance. v. Consider an order for PT referral to evaluate the need/appropriate device. 3. In the event that alternatives prove ineffective, the Licensed Nurse will assess the resident for the appropriate use of approved Sunrise assistive devices: (Halo, Deluxe Assist Handle, over the bed	02310		

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02310	Continued From page 65 trapeze, and bathroom grab bars). a. Bathroom grab bars may include grab bars for the toilet and, if applicable, the bathtub or shower. 4. If it is determined that the use of an assistive device is appropriate and permitted by state/province regulation/law, the Resident Care Director (RCD)/LN shall: a. Consult with the resident's physician and the resident's legal representative. b. The legal representative will be informed of the potential risks and benefits of using the proposed assistive device and the discussion and conclusion is documented in the wellness record. c. After consultation with and obtaining signed consent from the resident/resident's legal representative (Acknowledgement And Consent For The Use Of A Transfer Assistive Device) and approval from the physician for the use of an assistive device. d. The RCD/Licensed Nurse obtains the physician order which will include m1:1st specify the type of device to be used, reason for the device (for example: bed mobility, repositioning, transfer assist, etc.), and documents the consultation in the progress notes.and [sic] updates the residents service plan. 5. In the event that the assistive device(s) are to be applied to the resident's bed, the RCD/Licensed Nurse shall notify the Maintenance department for installation. a. A trained Maintenance Coordinator (MC)/Maintenance Team Member will coordinate with vendors to install assistive devices to a qualifying bed using the manufacturer instructions/recommendations and will test the bed for entrapment risks using the bed entrapment measuring tool.	02310		

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02310	Continued From page 66 i. An alternate trained team member may coordinate/install the device using the manufacturer instructions/recommendations and will test the bed for entrapment risks in the absence of a trained maintenance team member. 1. This training must be documented and filed in the team members training file. b. Assistive Device Log will be maintained in the safety program binder in the community. c. The MC/designee will inspect and test each bed system/assistive device on a monthly basis for safety and risk of entrapment i. Test results are documented on to the Healthcare Bed Test & Inspection Log and uploaded into TELS. ii. If an assistive device fails inspection the MC/designee shall: 1. Immediately notify the Executive Director (ED)/RCD that the bed or assistive device needs to be removed from service. 2. The ED/RCD/designee will notify the family that an issue has arisen with the assistive device and include them in the resolution if needed. 3. The RCD/designee shall put alternative interventions in place for resident until bed system/assistive device is repaired or replaced." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

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 EDINA
7128 FRANCE AVENUE SOUTH
Edina, MN 55435
Hennepin County
Parcel:

Phone:

License Info

License: HFID 21787

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1013251101
Inspection Type: Full - Single
Date: 10/20/2025 Time: 12:30 pm
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 2
Total Priority 2 Orders: 1
Total Priority 3 Orders: 4
Delivery:

New Order: 2-100 Supervision
2-102.12AMN *Priority Level: Priority 3 CFP#: 2*
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
COMMENT: 10/20/25 REPEAT
NO MN CFPM IS EMPLOYED AT THE FACILITY. COMPLY WITH RULE. MN CFPM INFORMATION WAS PROVIDED. ORDER WAS ISSUED ON 1/9/23.
Comply By: 10/20/2025 Originally Issued On: 10/20/2025

! **New Order: 3-300B Protection from Contamination: cross-contamination, eggs**
3-302.11A(2) *Priority Level: Priority 1 CFP#: 15*
MN Rule 4626.0235A(2) Separate types of raw animal foods from other raw animal foods during storage, preparation and display based on cook temperature.
COMMENT: BOX OF RAW BEEF WAS ON A TRAY DIRECTLY ABOVE A TRAY OF RAW SHRIMP LOCATED IN THE WALK-IN COOLER. COMPLY WITH RULE. DISCUSSED FOOD STORAGE AND THE RAW BEEF WAS MOVED BELOW AND AWAY.
Comply By: Complied On Site Originally Issued On: 10/20/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.14 *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
COMMENT: QUATERNARY AMMONIA SANITIZER IS USED IN THE KITCHEN. NO QUAT TEST KIT WAS AVAILABLE. COMPLY WITH RULE. STAFF ORDERED TEST STRIPS.
Comply By: 10/27/2025 Originally Issued On: 10/20/2025

New Order: 4-600 Cleaning Equipment and Utensils
4-602.13 *Priority Level: Priority 3 CFP#: 49*
MN Rule 4626.0855 Clean all non-food-contact surfaces of equipment at a frequency necessary to preclude accumulation of soil residues.
COMMENT: GRIME BUILDUP WAS LOCATED ON THE STEAM TABLE EDGES NEAR THE FOOD PANS. COMPLY WITH RULE. DISCUSSED CLEANING PROCEDURES WITH STAFF.
Comply By: 10/20/2025 Originally Issued On: 10/20/2025

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.110B *Priority Level: Priority 3 CFP#: 56*
MN Rule 4626.1560B Use the lockers or other suitable facilities to store clothing and other possessions.
COMMENT: STAFF JACKETS AND PERSONAL ITEMS WERE STORED ON THE DRY STORAGE RACKS (PACKAGED FOOD STORAGE). COMPLY WITH RULE.
Comply By: 10/20/2025 Originally Issued On: 10/20/2025

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: GRIME AND DEBRIS BUILDUP LOCATED ON THE FLOOR BELOW AND BEHIND COOKING EQUIPMENT ON THE COOK LINE. COMPLY WITH RULE. DISCUSSED CLEANING PROCEDURES WITH STAFF.
Comply By: 10/20/2025 Originally Issued On: 10/20/2025

! **New Order: 7-200 Toxic Supplies and Applications**
7-204.11 *Priority Level: Priority 1 CFP#: 28*
MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.
COMMENT: QUATERNARY AMMONIA SANITIZER MEASURED OVER 500 PPM IN THE KITCHEN AREAS (SANITIZER BUCKET, DISPENSER, SPRAY BOTTLE). COMPLY WITH RULE. DISCUSSED SANITIZER USE AND ADDING WATER TO DILUTE THE SANITIZER TO THE CORRECT RANGE (150 TO 400 PPM PER LABEL). RECOMMENDED HAVING A TECH SERVICE THE SANITIZER DISPENSER.
Comply By: 10/20/2025 Originally Issued On: 10/20/2025

Food & Beverage General Comment

The inspection was completed with the operator then reviewed with MDH Nurse Evaluator D. Mosissa.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, food storage, and food handling procedures.

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 F1013251101 from 10/20/2025

Anthony Guerrieri
Manager

Jerry Malloy

Jerry Malloy,
Public Health Sanitarian Supervisor
651-201-3998
jerry.malloy@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 EDINA
Edina
County/Group: Hennepin County

Inspection Info

Report Number: F1013251101
Inspection Type: Full
Date: 10/20/2025
Time: 12:30 pm

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

Food Temperature: Product/Item/Unit: Green beans**; Temperature Process:** Hot-Holding
Location: Steam Table at 147 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Ravioli**; Temperature Process:** Hot-Holding
Location: Steam Table at 194 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Soup**; Temperature Process:** Hot-Holding
Location: Warmer at 138 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Sliced melon**; Temperature Process:** Cold-Holding
Location: Tall cooler at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Burger**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 38 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Dressing**; Temperature Process:** Cold-Holding
Location: Low cooler at 41 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

SUNRISE OF EDINA
Edina
County/Group: Hennepin County

Inspection Info

Report Number: F1013251101
Inspection Type: Full
Date: 10/20/2025
Time: 12:30 pm

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Dispenser
Location: Dishwashing Area **Greater Than** 500 PPM
Comment:
Violation Issued?: Yes

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
Location: Kitchen **Greater Than** 500 PPM
Comment:
Violation Issued?: Yes

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 182 Degrees F.
Comment:
Violation Issued?: No