



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

December 7, 2023

Licensee  
Sunrise Of Golden Valley  
4950 Olson Memorial Highway  
Golden Valley, MN 55422

RE: Project Number(s) SL23982015

Dear Licensee:

On November 21, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the August 2, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Casey DeVries'.

Casey DeVries, Supervisor  
State Evaluation Team  
Email: [casey.devries@state.mn.us](mailto:casey.devries@state.mn.us)  
Telephone: 651-201-5917 Fax: 1-866-890-9290

PMB





*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered

November 3, 2023

Licensee  
Sunrise Of Golden Valley  
4950 Olson Memorial Highway  
Golden Valley, MN 55422

RE: Project Number(s) SL23982015

Dear Licensee:

On October 18, 2023, 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 August 2, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the August 2, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on August 2, 2023, found not corrected at the time of the October 18, 2023, follow-up survey and/or subject to penalty assessment are as follows:

**2310-Appropriate Care And Services-144g.91 Subd. 4 (a) - \$3,000.00**

The details of the violations noted at the time of this follow-up survey completed on October 18, 2023 (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 \$3,000.00**. 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.

**IMPOSITION OF FINES:**

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in §144G.20 for widespread violations;

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

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



### **CORRECTION ORDER RECONSIDERATION PROCESS**

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

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

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

Please address your cover letter for reconsideration requests to:

Reconsideration Unit  
Health Regulation Division  
Minnesota Department of Health  
HRD 3A, 3rd Floor  
P.O. Box 64900  
625 Robert Street North  
St. Paul, MN 55155

### **REQUESTING A HEARING**

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

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

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917.



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,

A handwritten signature in black ink, reading "Casey DeVries". The signature is written in a cursive, flowing style.

Casey DeVries, Supervisor  
State Evaluation Team  
Email: [casey.devries@state.mn.us](mailto:casey.devries@state.mn.us)  
Telephone: 651-201-5917 Fax: 1-866-890-9290

PMB



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                   |
|--------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>23982                                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | (X3) DATE SURVEY COMPLETED<br><br>R<br>10/18/2023 |
| NAME OF PROVIDER OR SUPPLIER<br><br>SUNRISE OF GOLDEN VALLEY |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br>4950 OLSON MEMORIAL HIGHWAY<br>GOLDEN VALLEY, MN 55422 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                   |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | (X5)<br>COMPLETE<br>DATE                          |
| {0 000}                                                      | <p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING<br/>CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.</p> <p>INITIAL COMMENTS:<br/>SL23982015-1</p> <p>On October 17, 2023, through October 18, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on August 2, 2023. At the time of the survey, there were 44 residents, all of whom received services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued.</p> | {0 000}                                                                                         | <p>Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.</p> <p>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.</p> |  |                                                   |
| {0 250}<br>SS=F                                              | <p>144G.20 Subdivision 1 Conditions</p> <p>(a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | {0 250}                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                   |

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                         |                                                                                                                          |  |                                                                    |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>10/18/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 250}                                                             | Continued From page 1<br><br>result of a change in ownership, refuse to renew<br>a license, suspend or revoke a license, or impose<br>a conditional license if the owner, controlling<br>individual, or employee of an assisted living<br>facility:<br>(1) is in violation of, or during the term of the<br>license has violated, any of the requirements in<br>this chapter or adopted rules;<br>(2) permits, aids, or abets the commission of any<br>illegal act in the provision of assisted living<br>services;<br>(3) performs any act detrimental to the health,<br>safety, and welfare of a resident;<br>(4) obtains the license by fraud or<br>misrepresentation;<br>(5) knowingly makes a false statement of a<br>material fact in the application for a license or in<br>any other record or report required by this<br>chapter;<br>(6) denies representatives of the department<br>access to any part of the facility's books, records,<br>files, or employees;<br>(7) interferes with or impedes a representative of<br>the department in contacting the facility's<br>residents;<br>(8) interferes with or impedes ombudsman<br>access according to section 256.9742,<br>subdivision 4, or interferes with or impedes<br>access by the Office of Ombudsman for Mental<br>Health and Developmental Disabilities according<br>to section 245.94, subdivision 1;<br>(9) interferes with or impedes a representative of<br>the department in the enforcement of this chapter<br>or fails to fully cooperate with an inspection,<br>survey, or investigation by the department;<br>(10) destroys or makes unavailable any records<br>or other evidence relating to the assisted living<br>facility's compliance with this chapter;<br>(11) refuses to initiate a background study under | {0 250}                                                                                                 |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                         |                                                                                                                          |  |                                                                    |
|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>10/18/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 250}                                                             | Continued From page 2<br><br>section 144.057 or 245A.04;<br>(12) fails to timely pay any fines assessed by the commissioner;<br>(13) violates any local, city, or township ordinance relating to housing or assisted living services;<br>(14) has repeated incidents of personnel performing services beyond their competency level; or<br>(15) has operated beyond the scope of the assisted living facility's license category.<br>(b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility.<br><br>This MN Requirement is not met as evidenced by:<br>No further action required.                                                                                                                                                                                                                                                                                                             | {0 250}                                                                                                 |                                                                                                                          |  |                                                                    |
| {0 470}<br>SS=F                                                     | <b>144G.41 Subdivision 1 Minimum requirements</b><br><br>(11) develop and implement a staffing plan for determining its staffing level that:<br>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;<br>(ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and<br>(iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility;<br>(12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: | {0 470}                                                                                                 |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                               |                                                                                                                          |  |                                                                    |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>10/18/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY</b><br><b>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 470}                                                             | Continued From page 3<br><br>(i) awake;<br>(ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time;<br>(iii) capable of communicating with residents;<br>(iv) capable of providing or summoning the appropriate assistance; and<br>(v) capable of following directions;<br><br>This MN Requirement is not met as evidenced by:<br>No further action required.                                                                           | {0 470}                                                                                                       |                                                                                                                          |  |                                                                    |
| {0 480}<br>SS=F                                                     | <b>144G.41 Subd 1 (13) (i) (B) Minimum requirements</b><br><br>(13) offer to provide or make available at least the following services to residents:<br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and<br><br>This MN Requirement is not met as evidenced by:<br>No further action required.                                                                                                                                                                                    | {0 480}                                                                                                       |                                                                                                                          |  |                                                                    |
| {0 510}<br>SS=F                                                     | <b>144G.41 Subd. 3 Infection control program</b><br><br>(a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.<br>(b) The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in | {0 510}                                                                                                       |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                               |                                                                                                                          |  |                                                                    |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>10/18/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY</b><br><b>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 510}                                                             | Continued From page 4<br><br>assisted living facilities.<br>(c) The facility must maintain written evidence of<br>compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced<br>by:<br>No further action required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | {0 510}                                                                                                       |                                                                                                                          |  |                                                                    |
| {0 650}<br>SS=F                                                     | <b>144G.42 Subd. 8 Employee records</b><br><br>(a) The facility must maintain current records of<br>each paid employee, each regularly scheduled<br>volunteer providing services, and each individual<br>contractor providing services. The records must<br>include the following information:<br>(1) evidence of current professional licensure,<br>registration, or certification if licensure,<br>registration, or certification is required by this<br>chapter or rules;<br>(2) records of orientation, required annual training<br>and infection control training, and competency<br>evaluations;<br>(3) current job description, including<br>qualifications, responsibilities, and identification of<br>staff persons providing supervision;<br>(4) documentation of annual performance<br>reviews that identify areas of improvement<br>needed and training needs;<br>(5) for individuals providing assisted living<br>services, verification that required health<br>screenings under subdivision 9 have taken place<br>and the dates of those screenings; and<br>(6) documentation of the background study as<br>required under section 144.057.<br><br>This MN Requirement is not met as evidenced<br>by:<br>No further action required. | {0 650}                                                                                                       |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                         |                                                                                                                          |  |                                                                    |
|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>10/18/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 660}                                                             | Continued From page 5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | {0 660}                                                                                                 |                                                                                                                          |  |                                                                    |
| {0 660}<br>SS=F                                                     | <b>144G.42 Subd. 9 Tuberculosis prevention and control</b><br><br>(a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.<br>(b) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>No further action required. | {0 660}                                                                                                 |                                                                                                                          |  |                                                                    |
| {0 680}<br>SS=F                                                     | <b>144G.42 Subd. 10 Disaster planning and emergency preparedness</b><br><br>(a) The facility must meet the following requirements:<br>(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;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor;                                                                                                                                                                                                                                                                                                                            | {0 680}                                                                                                 |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                 |                                                                                                                          |  |                                                   |
|--------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>23982                                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>R<br>10/18/2023 |
| NAME OF PROVIDER OR SUPPLIER<br><br>SUNRISE OF GOLDEN VALLEY |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br>4950 OLSON MEMORIAL HIGHWAY<br>GOLDEN VALLEY, MN 55422 |                                                                                                                          |  |                                                   |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                          |
| {0 680}                                                      | Continued From page 6<br><br>and<br>(5) have a written policy and procedure regarding missing residents.<br>(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.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>No further action required.                                                                                                                                                                                                     | {0 680}                                                                                         |                                                                                                                          |  |                                                   |
| {0 730}<br>SS=F                                              | 144G.43 Subd. 3 Contents of resident record<br><br>Contents of a resident record include the following for each resident:<br>(1) identifying information, including the resident's name, date of birth, address, and telephone number;<br>(2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative;<br>(3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known;<br>(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;<br>(5) the resident's advance directives, if any;<br>(6) copies of any health care directives, guardianships, powers of attorney, or | {0 730}                                                                                         |                                                                                                                          |  |                                                   |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                 |                                                                                                                          |  |                                                   |
|--------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>23982                                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>R<br>10/18/2023 |
| NAME OF PROVIDER OR SUPPLIER<br><br>SUNRISE OF GOLDEN VALLEY |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br>4950 OLSON MEMORIAL HIGHWAY<br>GOLDEN VALLEY, MN 55422 |                                                                                                                          |  |                                                   |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                          |
| {0 730}                                                      | Continued From page 7<br><br>conservatorships;<br>(7) the facility's current and previous assessments and service plans;<br>(8) all records of communications pertinent to the resident's services;<br>(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;<br>(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;<br>(11) documentation that services have been provided as identified in the service plan;<br>(12) documentation that the resident has received and reviewed the assisted living bill of rights;<br>(13) documentation of complaints received and any resolution;<br>(14) a discharge summary, including service termination notice and related documentation, when applicable; and<br>(15) other documentation required under this chapter and relevant to the resident's services or status.<br><br>This MN Requirement is not met as evidenced by:<br>No further action required. | {0 730}                                                                                         |                                                                                                                          |  |                                                   |
| {0 800}<br>SS=F                                              | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | {0 800}                                                                                         |                                                                                                                          |  |                                                   |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                         |                                                                                                                          |  |                                                                 |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b>                                  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>10/18/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |  |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                        |
| {0 800}                                                             | Continued From page 8<br><br>health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.<br><br>This MN Requirement is not met as evidenced by:<br>No further action required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | {0 800}                                                                                                 |                                                                                                                          |  |                                                                 |
| {0 810}<br>SS=F                                                     | <b>144G.45 Subd. 2 (b)-(f) Fire protection and physical environment</b><br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.<br>(c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.<br>(f) Evacuation drills are required for employees | {0 810}                                                                                                 |                                                                                                                          |  |                                                                 |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                         |                                                                                                                          |  |                                                                    |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>10/18/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {0 810}                                                             | Continued From page 9<br><br>twice per year per shift with at least one<br>evacuation drill every other month. Evacuation of<br>the residents is not required. Fire alarm system<br>activation is not required to initiate the evacuation<br>drill.<br><br>This MN Requirement is not met as evidenced<br>by:<br>No further action required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | {0 810}                                                                                                 |                                                                                                                          |  |                                                                    |
| {01470}<br>SS=F                                                     | 144G.63 Subd. 2 Content of required orientation<br><br>(a) The orientation must contain the following<br>topics:<br>(1) an overview of this chapter;<br>(2) an introduction and review of the facility's<br>policies and procedures related to the provision<br>of assisted living services by the individual staff<br>person;<br>(3) handling of emergencies and use of<br>emergency services;<br>(4) compliance with and reporting of the<br>maltreatment of vulnerable adults under section<br>626.557 to the Minnesota Adult Abuse Reporting<br>Center (MAARC);<br>(5) the assisted living bill of rights and staff<br>responsibilities related to ensuring the exercise<br>and protection of those rights;<br>(6) the principles of person-centered planning<br>and service delivery and how they apply to direct<br>support services provided by the staff person;<br>(7) handling of residents' complaints, reporting of<br>complaints, and where to report complaints,<br>including information on the Office of Health<br>Facility Complaints;<br>(8) consumer advocacy services of the Office of<br>Ombudsman for Long-Term Care, Office of<br>Ombudsman for Mental Health and | {01470}                                                                                                 |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                         |                                                                                                                          |  |                                                                 |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b>                                  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>10/18/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |  |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                        |
| {01470}                                                             | Continued From page 10<br><br>Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and<br>(9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure.<br>(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:<br>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;<br>(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>No further action required. | {01470}                                                                                                 |                                                                                                                          |  |                                                                 |
| {01500}<br>SS=E                                                     | 144G.63 Subd. 5 Required annual training<br><br>(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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | {01500}                                                                                                 |                                                                                                                          |  |                                                                 |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                         |                                                                                                                          |  |                                                                 |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b>                                  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>10/18/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |  |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                        |
| {01500}                                                             | <p>Continued From page 11</p> <p>source and must include topics relevant to the provision of assisted living services. The annual training must include:</p> <p>(1) training on reporting of maltreatment of vulnerable adults under section 626.557;</p> <p>(2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;</p> <p>(3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;</p> <p>(4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;</p> <p>(5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and</p> <p>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.</p> <p>(b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:</p> <p>(1) an explanation of age-related hearing loss</p> | {01500}                                                                                                 |                                                                                                                          |  |                                                                 |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                         |                                                                                                                          |  |                                                                    |
|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>10/18/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {01500}                                                             | Continued From page 12<br><br>and how it manifests itself, its prevalence, and<br>challenges it poses to communication;<br>(2) the health impacts related to untreated<br>age-related hearing loss, such as increased<br>incidence of dementia, falls, hospitalizations,<br>isolation, and depression; or<br>(3) information about strategies and technology<br>that may enhance communication and<br>involvement, including communication strategies,<br>assistive listening devices, hearing aids, visual<br>and tactile alerting devices, communication<br>access in real time, and closed captions.<br><br>This MN Requirement is not met as evidenced<br>by:<br>No further action required.                                                                                                                                                                                                                                                                                                  | {01500}                                                                                                 |                                                                                                                          |  |                                                                    |
| {01540}<br>SS=E                                                     | <b>144G.64 (a) TRAINING IN DEMENTIA CARE<br/>REQUIRED</b><br><br>(3) for assisted living facilities with dementia care,<br>direct-care employees must have completed at<br>least eight hours of initial training on topics<br>specified under paragraph (b) within 80 working<br>hours of the employment start date. Until this<br>initial training is complete, an employee must not<br>provide direct care unless there is another<br>employee on site who has completed the initial<br>eight hours of training on topics related to<br>dementia care and who can act as a resource<br>and assist if issues arise. A trainer of the<br>requirements under paragraph (b) or a supervisor<br>meeting the requirements in clause (1) must be<br>available for consultation with the new employee<br>until the training requirement is complete.<br>Direct-care employees must have at least two<br>hours of training on topics related to dementia for<br>each 12 months of employment thereafter; | {01540}                                                                                                 |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                               |                                                                                                                          |  |                                                                    |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>10/18/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY</b><br><b>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {01540}                                                             | Continued From page 13<br><br>This MN Requirement is not met as evidenced<br>by:<br>No further action required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | {01540}                                                                                                       |                                                                                                                          |  |                                                                    |
| {01620}<br>SS=E                                                     | <b>144G.70 Subd. 2 (c-e) Initial reviews,<br/>assessments, and monitoring</b><br><br>(c) Resident reassessment and monitoring must<br>be conducted no more than 14 calendar days<br>after initiation of services. Ongoing resident<br>reassessment and monitoring must be conducted<br>as needed based on changes in the needs of the<br>resident and cannot exceed 90 calendar days<br>from the last date of the assessment.<br>(d) For residents only receiving assisted living<br>services specified in section 144G.08, subdivision<br>9, clauses (1) to (5), the facility shall complete an<br>individualized initial review of the resident's needs<br>and preferences. The initial review must be<br>completed within 30 calendar days of the start of<br>services. Resident monitoring and review must<br>be conducted as needed based on changes in<br>the needs of the resident and cannot exceed 90<br>calendar days from the date of the last review.<br>(e) A facility must inform the prospective resident<br>of the availability of and contact information for<br>long-term care consultation services under<br>section 256B.0911, prior to the date on which a<br>prospective resident executes a contract with a<br>facility or the date on which a prospective<br>resident moves in, whichever is earlier.<br><br>This MN Requirement is not met as evidenced<br>by:<br>No further action required. | {01620}                                                                                                       |                                                                                                                          |  |                                                                    |
| {01640}<br>SS=E                                                     | <b>144G.70 Subd. 4 (a-e) Service plan,<br/>implementation and revisions to</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | {01640}                                                                                                       |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        |                                                                                                                          |  |                                                                 |
|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>10/18/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                        |
| {01640}                                                             | Continued From page 14<br><br>(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.<br>(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.<br>(c) The facility must implement and provide all services required by the current service plan.<br>(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.<br>(e) Staff providing services must be informed of the current written service plan.<br><br>This MN Requirement is not met as evidenced by:<br>No further action required. | {01640}                                                                |                                                                                                                          |  |                                                                 |
| {01730}<br>SS=D                                                     | 144G.71 Subd. 5 Individualized medication management plan<br><br>(a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | {01730}                                                                |                                                                                                                          |  |                                                                 |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                               |                                                                                                                          |  |                                                                    |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>10/18/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY</b><br><b>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {01730}                                                             | Continued From page 15<br><br>(1) a statement describing the medication management services that will be provided;<br>(2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;<br>(3) documentation of specific resident instructions relating to the administration of medications;<br>(4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;<br>(5) identification of medication management tasks that may be delegated to unlicensed personnel;<br>(6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and<br>(7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.<br>(b) The medication management record must be current and updated when there are any changes.<br>(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.<br><br>This MN Requirement is not met as evidenced by:<br>No further action required. | {01730}                                                                                                       |                                                                                                                          |  |                                                                    |
| {01760}<br>SS=D                                                     | 144G.71 Subd. 8 Documentation of administration of medication                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | {01760}                                                                                                       |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                         |                                                                                                                          |  |                                                                    |
|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>10/18/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {01760}                                                             | Continued From page 16<br><br>Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.<br><br>This MN Requirement is not met as evidenced by:<br>No further action required. | {01760}                                                                                                 |                                                                                                                          |  |                                                                    |
| {01820}<br>SS=D                                                     | <b>144G.71 Subd. 13 Prescriptions</b><br><br>There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident.<br><br>This MN Requirement is not met as evidenced by:<br>No further action required.                                                                                                                                                                                                                                                                                                                                                                                                                              | {01820}                                                                                                 |                                                                                                                          |  |                                                                    |
| {01880}<br>SS=F                                                     | <b>144G.71 Subd. 19 Storage of medications</b><br><br>An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | {01880}                                                                                                 |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        |                                                                                                                          |  |                                                                 |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>10/18/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                        |
| {01880}                                                             | Continued From page 17<br><br>This MN Requirement is not met as evidenced by:<br>No further action required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | {01880}                                                                |                                                                                                                          |  |                                                                 |
| {01890}<br>SS=D                                                     | 144G.71 Subd. 20 Prescription drugs<br><br>A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.<br><br>This MN Requirement is not met as evidenced by:<br>No further action required.                                                                                                                                                                                                                                                                                                                                                                                                                             | {01890}                                                                |                                                                                                                          |  |                                                                 |
| {01940}<br>SS=D                                                     | 144G.72 Subd. 3 Individualized treatment or therapy management<br><br>For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following:<br>(1) a statement of the type of services that will be provided;<br>(2) documentation of specific resident instructions relating to the treatments or therapy administration;<br>(3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel;<br>(4) procedures for notifying a registered nurse or | {01940}                                                                |                                                                                                                          |  |                                                                 |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                           |                                                                                                                          |  |                                                                    |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>10/18/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {01940}                                                             | <b>Continued From page 18</b><br><br>appropriate licensed health professional when a problem arises with treatments or therapy services; and<br>(5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.<br><br>This MN Requirement is not met as evidenced by:<br>No further action required. | {01940}                                                                   |                                                                                                                          |  |                                                                    |
| {01970}<br>SS=D                                                     | <b>144G.72 Subd. 6 Treatment and therapy orders</b><br><br>There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months.<br><br>This MN Requirement is not met as evidenced by:<br>No further action required.                                               | {01970}                                                                   |                                                                                                                          |  |                                                                    |
| {02040}<br>SS=F                                                     | <b>144G.81 Subdivision 1 Fire protection and physical environment</b><br><br>An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the                                                                                                                                                                                                                                                                                                                                                                                                 | {02040}                                                                   |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                 |                                                                                                                          |  |                                                   |
|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>23982                                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>R<br>10/18/2023 |
| NAME OF PROVIDER OR SUPPLIER<br><br>SUNRISE OF GOLDEN VALLEY |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br>4950 OLSON MEMORIAL HIGHWAY<br>GOLDEN VALLEY, MN 55422 |                                                                                                                          |  |                                                   |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                          |
| {02040}                                                      | Continued From page 19<br><br>following additional requirements:<br>(1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and<br>(2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029.<br><br>This MN Requirement is not met as evidenced by:<br>No further action required. | {02040}                                                                                         |                                                                                                                          |  |                                                   |
| {02090}<br>SS=D                                              | 144G.82 Subdivision 1 General<br><br>The licensee of an assisted living facility with dementia care is responsible for the care and housing of the persons with dementia and the provision of person-centered care that promotes each resident's dignity, independence, and comfort. This includes the supervision, training, and overall conduct of the staff.<br><br>This MN Requirement is not met as evidenced by:<br>No further action required.                                                 | {02090}                                                                                         |                                                                                                                          |  |                                                   |
| {02110}<br>SS=C                                              | 144G.82 Subd. 3 Policies<br><br>(a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the:<br>(1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy                                                             | {02110}                                                                                         |                                                                                                                          |  |                                                   |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                         |                                                                                                                          |  |                                                                    |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>10/18/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {02110}                                                             | Continued From page 20<br><br>shall be implemented;<br>(2) evaluation of behavioral symptoms and<br>design of supports for intervention plans,<br>including nonpharmacological practices that are<br>person-centered and evidence-informed;<br>(3) wandering and egress prevention that<br>provides detailed instructions to staff in the event<br>a resident elopes;<br>(4) medication management, including an<br>assessment of residents for the use and effects<br>of medications, including psychotropic<br>medications;<br>(5) staff training specific to dementia care;<br>(6) description of life enrichment programs and<br>how activities are implemented;<br>(7) description of family support programs and<br>efforts to keep the family engaged;<br>(8) limiting the use of public address and<br>intercom systems for emergencies and<br>evacuation drills only;<br>(9) transportation coordination and assistance to<br>and from outside medical appointments; and<br>(10) safekeeping of residents' possessions.<br>(b) The policies and procedures must be provided<br>to residents and the residents' legal and<br>designated representatives at the time of<br>move-in.<br><br>This MN Requirement is not met as evidenced<br>by:<br>No further action required. | {02110}                                                                                                 |                                                                                                                          |  |                                                                    |
| {02310}<br>SS=I                                                     | 144G.91 Subd. 4 (a) Appropriate care and<br>services<br><br>(a) Residents have the right to care and assisted<br>living services that are appropriate based on the<br>resident's needs and according to an up-to-date<br>service plan subject to accepted health care                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | {02310}                                                                                                 |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                 |                                                                                                                          |  |                                                   |
|--------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>23982 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>R<br>10/18/2023 |
| NAME OF PROVIDER OR SUPPLIER<br><br>SUNRISE OF GOLDEN VALLEY |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>4950 OLSON MEMORIAL HIGHWAY<br>GOLDEN VALLEY, MN 55422                          |  |                                                   |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                          |
| {02310}                                                      | <p>Continued From page 21</p> <p>standards.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for five of five residents (R3, R9, R12, R16, R17) with an assistive device (consumer bed rail).</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>R3<br/>R3 admitted to the licensee on May 16, 2023, and began receiving assisted living services.</p> <p>R3's service plan signed May 19, 2023, indicated R3 received assistance with meals, medication management, oral care, transfers, grooming, dressing, toileting, bathing, laundry, and housekeeping.</p> <p>On October 18, 2023, at 11:05 a.m., the surveyor observed bilateral halo assistive devices on R3's bed.</p> <p>R3's Acknowledgment and Consent for the Use of a Transfer Assistive Device dated August 3, 2023, indicated the consent of use of a halo assistive</p> | {02310}                                                         |                                                                                                                          |  |                                                   |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                           |                                                                                                                          |  |                                                                    |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>10/18/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {02310}                                                             | <p>Continued From page 22</p> <p>device for R3.</p> <p>R3 ongoing-assessment titled MN 3.0 SEHA -V10 effective May 23, 2023, indicated R3 was legally blind in right and left eye, was orientated to person and confused, continent of bowel and bladder, independent with bed mobility, and transferred assisted of one. The assessment did not include information on R3's use of halo assistive device.</p> <p>R9<br/>R9 admitted to the licensee on May 4, 2023, and began receiving assisted living services.</p> <p>R9's service plan signed August 23, 2023, indicated R9 received assistance with medication management, behavior management, meals, mobility, transfers, grooming, toileting, bathing, laundry, and housekeeping. In addition, the service plan indicated R9 used a halo assist handle for bed mobility and transfers, the halo assistive device was inspected by maintenance and a registered nurse (RN) monthly, and unlicensed personnel were to observe halo assistive device and report to RN if not working properly.</p> <p>On October 18, 2023, at 10:59 a.m., the surveyor observed bilateral halo assistive devices on R9's bed.</p> <p>R9's Acknowledgment and Consent for the Use of a Transfer Assistive Device dated August 3, 2023, indicated the consent of use of a halo assistive device for R9.</p> <p>R9's ongoing-assessment titled MN 3.0 SEHA-V10 effective date June 24, 2023, indicated R9 was orientated to person, place and</p> | {02310}                                                                   |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                         |                                                                                                                          |  |                                                                    |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>10/18/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {02310}                                                             | <p>Continued From page 23</p> <p>time, was continent of bowel and bladder, had limited range of motion to the legs, left lower extremity was amputated, used antidepressants, had behavioral concerns, was assist of one for mobility, used a Halo assist handle device to assist with transfers and bed mobility, and transferred assist of two.</p> <p>R12<br/>R12 admitted to the licensee on January 2, 2012, under the licensee's former comprehensive license and began receiving assisted living services August 1, 2021.</p> <p>R12's service plan signed June 23, 2023, indicated R12 received assistance with medication management, oral care, meals, toileting, escorts, grooming, bathing, laundry, and housekeeping. In addition, the service plan indicated R12 used a halo assist handle for bed mobility and transfers, the halo assistive device was inspected by maintenance and a registered nurse (RN) monthly, and unlicensed personnel were to observe halo assistive device and report to RN if not working properly.</p> <p>On October 18, 2023, at 11:03 a.m., the surveyor observed bilateral halo assistive devices on R12's bed.</p> <p>R12's Acknowledgment and Consent for the Use of a Transfer Assistive Device dated August 25, 2023, indicated the consent of use of a halo assistive device for R12.</p> <p>R12's ongoing-assessment titled MN 3.0 SEHA-V10 effective date July 26, 2023, indicated R12 was incontinent of bowel and bladder, orientated to person, place and time, received antidepressants, and had a hospital bed with a</p> | {02310}                                                                                                 |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                           |                                                                                                                          |  |                                                                    |
|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>10/18/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {02310}                                                             | <p>Continued From page 24</p> <p>halo device to assist with transferring in and out of bed.</p> <p>R16<br/>R16 admitted to the licensee on May 6, 2023, and began receiving assisted living services.</p> <p>R16's service plan signed June 28, 2023, indicated R16 received assistance with edema management, medication management, transportation, activities, oral care, meals, toileting, behavior management, mobility, transfers, grooming, dressing, bathing, laundry, and housekeeping.</p> <p>On October 18, 2023, at 11:01 a.m., the surveyor observed bilateral halo assistive devices on R16's bed.</p> <p>R16's Acknowledgment and Consent for the Use of a Transfer Assistive Device dated August 3, 2023, indicated the consent of use of a halo assistive device for R16.</p> <p>R16's ongoing-assessment titled MN 3.0 SEHA-V10 effective date June 24, 2023, indicated R16 had impaired cognitive function, pitting edema to the lower extremities, needed assistance of one for toileting to maintain bowel and bladder continence, had limited range of motions to the arms, displayed disruptive behaviors, was assist of one for mobility, and transferred assist of two. The assessment did not include information on R16's use of halo device.</p> <p>R17<br/>R17 admitted to the licensee on June 20, 2023, and began receiving assisted living services.</p> <p>R17 service plan signed September 14, 2023,</p> | {02310}                                                                   |                                                                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        |                                                                                                                          |  |                                                                 |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>10/18/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                        |
| {02310}                                                             | <p>Continued From page 25</p> <p>indicated R17 received assistance with medication management, oral care, meals, toileting, escorts, mobility, transfer, grooming, dressing, laundry, and housekeeping. In addition, the service plan indicated R17 used a halo assist handle for bed mobility and transfers, the halo assistive device was inspected by maintenance and a registered nurse (RN) monthly, and unlicensed personnel were to observe halo assistive device and report to RN if not working properly.</p> <p>R17's ongoing-assessment titled MN. 3.0 SEHA - V10 effective date June 20, 2023, indicated R17 used a halo assist handle device for bed mobility, was unable to communicate needs or requests for assistance, was incontinent of bowel and bladder, had impaired mobility, limited range of motion in the arms, had impaired safety awareness and/or decision-making ability, was assist of one for bed mobility, and assist of two with transfers.</p> <p>R17's progress note dated August 3, 2023, indicated R17's representative received risk and benefits via phone and gave verbal consent to use the halo assistive device.</p> <p>R17's progress note dated September 13, 2023, indicated R17's was no longer appropriate to use the halo assistive device due to safety concerns and device needed to be removed. R17's representative agreed with plan and wanted the halo device removed.</p> <p>R17's provider order dated September 14, 2023, included discontinue halo bars.</p> <p>On October 18, 2023, at 9:26 a.m., licensed assisted living director (LALD)-L stated R17's</p> | {02310}                                                                |                                                                                                                          |  |                                                                 |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        |                                                                                                                          |  |                                                                 |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>10/18/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                        |
| {02310}                                                             | <p>Continued From page 26</p> <p>halo assistive devices were removed.</p> <p>On October 18, 2023, at 11:06 a.m., the surveyor observed a halo assistive device on R17's left side of bed.</p> <p>R3, R9, R12, R16, and R17's record lacked the resident's bed rail use/need assessment to include:</p> <ul style="list-style-type: none"><li>-the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls;</li><li>-whether the bed rail is appropriate or has the effect of being an improper restraint.</li></ul> <p>On October 18, 2023, at 10:01 a.m., the surveyor requested resident assessments related to bed rails. LALD-L asked the surveyor what was needed on the assessment. The surveyor explained what items they were needed. LALD-L stated they were missing the assessment "piece" for bed rails.</p> <p>On October 18, 2023, at 10:27 a.m., clinical nurse supervisor (CNS)-C stated the licensee did not have a bed rail assessment. In addition, CNS-C stated they performed monthly safety rounds on the bed rails with maintenance personnel.</p> <p>On October 18, 2023, at 10:42 a.m., CNS-C stated they were aware a bed rail assessment needed to be completed but did not know it needed to be documented. LALD-L stated they believed it was a "bigger issue" because corporate had many businesses out of Minnesota that do not have the same regulations.</p> <p>On October 18, 2023, at approximately 11:06 a.m., CNS-C stated they were unaware why the</p> | {02310}                                                                |                                                                                                                          |  |                                                                 |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                 |                                                                                                                          |  |                                                   |
|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>23982                                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>R<br>10/18/2023 |
| NAME OF PROVIDER OR SUPPLIER<br><br>SUNRISE OF GOLDEN VALLEY |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br>4950 OLSON MEMORIAL HIGHWAY<br>GOLDEN VALLEY, MN 55422 |                                                                                                                          |  |                                                   |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                          |
| {02310}                                                      | <p>Continued From page 27</p> <p>halo device was still on R17's bed.</p> <p>On October 18, 2023, at 12:06 p.m., CNS-C stated when a resident requests use for an assistive device, they have a physical therapist or occupational therapist come and evaluate the resident for use, have a discussion with the family on risk and benefits and obtain a consent form, obtain a provider order for the assistive device, have maintenance install the assistive device, then the nurse and maintenance will assess the assistive device to insure it was installed appropriately. The surveyor asked how CNS-C assessed the residents for use of bed rail. CNS-C stated, "we make sure they know how to use, why its used, make sure they can safely transfer with it." In addition, CNS-C stated the resident should have the cognitive ability to know what the device is used for.</p> <p>The FDA document titled Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities, and Home Care Settings dated April 2003, recommended the decision to utilize or remove bed rails should occur within the framework of an individual resident assessment and should be documented clearly and approved by the interdisciplinary team. The resident chart should include a risk-benefit assessment that identifies why other interventions are not appropriate or effective.</p> <p>The Minnesota Department of Health (MDH) website, Assisted Living Resources &amp; Frequently Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for</p> | {02310}                                                                                         |                                                                                                                          |  |                                                   |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                 |                                                                                                                          |                          |                                                   |
|--------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>23982 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br>R<br>10/18/2023 |
| NAME OF PROVIDER OR SUPPLIER<br><br>SUNRISE OF GOLDEN VALLEY |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>4950 OLSON MEMORIAL HIGHWAY<br>GOLDEN VALLEY, MN 55422                          |                          |                                                   |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                   |
| {02310}                                                      | <p>Continued From page 28</p> <p>the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." The MDH website indicated for consumer bed rails, the licensee must include in their documentation:</p> <ul style="list-style-type: none"><li>- Purpose and intention of the bed rail;</li><li>- Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail;</li><li>- The resident's bed rail use/need assessment;</li><li>- Risk vs. benefits discussion (individualized to each resident's risks);</li><li>- The resident's preferences;</li><li>- Installation and use according to manufacturer's guidelines;</li><li>- Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and</li><li>- Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements".</li></ul> <p>The licensee's Assistive Devices policy dated February 14, 2022, indicated the licensed nurse would assess the resident for the appropriate use of approved devices and would evaluate the ongoing appropriateness of the assistive device monthly during the assessment process or the wellness visit. In addition, the legal representative would be informed of the potential risk and benefits of using the proposed assistive device and the discussion and conclusion was documented in the wellness record.</p> <p>No further information was provided.</p> | {02310}                                                         |                                                                                                                          |                          |                                                   |



Minnesota Department of Health

|                                                                     |                                                                                                                              |                                                                                                         |                                                                                                                          |  |                                                                    |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>10/18/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
|                                                                     |                                                                                                                              |                                                                                                         |                                                                                                                          |  |                                                                    |





*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

August 24, 2023

Licensee  
Sunrise Of Golden Valley  
4950 Olson Memorial Highway  
Golden Valley, MN 55422

RE: Project Number(s) SL23982015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 2, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

#### **STATE CORRECTION ORDERS**

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

#### **IMPOSITION OF FINES**

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

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. The MDH may impose a fine of \$1,000 for each substantiated maltreatment violation that consists of



abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

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

**St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$3,000.00**

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

#### **DOCUMENTATION OF ACTION TO COMPLY**

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

The correction order documentation should include the following:

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

#### **CORRECTION ORDER RECONSIDERATION PROCESS**

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

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



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

Please address your cover letter for reconsideration requests to:

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

### **REQUESTING A HEARING**

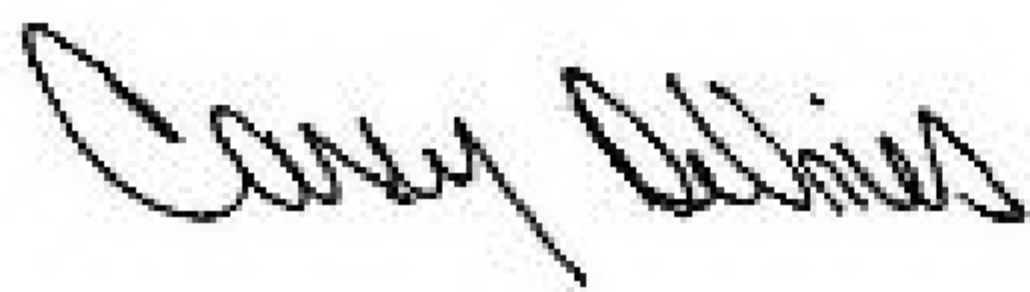
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for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

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

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor  
State Evaluation Team  
Email: casey.devries@state.mn.us  
Telephone: 651-201-5917 Fax: 651-281-9796

JMD



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                     |
|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b>                                  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 000                                                               | <p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING<br/>CORRECTION ORDER(S)</p> <p>In accordance with Minnesota Statutes, section<br/>144G.08 to 144G.95, these correction orders are<br/>issued pursuant to a survey.</p> <p>Determination of whether violations are corrected<br/>requires compliance with all requirements<br/>provided at the Statute number indicated below.<br/>When Minnesota Statute contains several items,<br/>failure to comply with any of the items will be<br/>considered lack of compliance.</p> <p>INITIAL COMMENTS:<br/>SL23982015-0</p> <p>On July 31, 2023, through August 2, 2023, the<br/>Minnesota Department of Health conducted a<br/>survey at the above provider, and the following<br/>correction orders are issued. At the time of the<br/>survey, there were 48 residents: all of whom<br/>received services under the Assisted Living with<br/>Dementia Care license.</p> <p>An immediate correction order was identified on<br/>August 2, 2023, issued for SL23982015-0, tag<br/>identification 2310.</p> <p>The immediacy of 2310 was not removed at the<br/>time of exit on August 2, 2023.</p> | 0 000                                                                                                   | <p>Minnesota Department of Health is<br/>documenting the State Correction Orders<br/>using federal software. Tag numbers have<br/>been assigned to Minnesota State<br/>Statutes for Assisted Living License<br/>Providers. The assigned tag number<br/>appears in the far-left column entitled "ID<br/>Prefix Tag." The state Statute number and<br/>the corresponding text of the state Statute<br/>out of compliance is listed in the<br/>"Summary Statement of Deficiencies"<br/>column. This column also includes the<br/>findings which are in violation of the state<br/>requirement after the statement, "This<br/>Minnesota requirement is not met as<br/>evidenced by." Following the surveyors'<br/>findings is the Time Period for Correction.</p> <p>PLEASE DISREGARD THE HEADING OF<br/>THE FOURTH COLUMN WHICH<br/>STATES,"PROVIDER'S PLAN OF<br/>CORRECTION." THIS APPLIES TO<br/>FEDERAL DEFICIENCIES ONLY. THIS<br/>WILL APPEAR ON EACH PAGE.</p> <p>THERE IS NO REQUIREMENT TO<br/>SUBMIT A PLAN OF CORRECTION FOR<br/>VIOLATIONS OF MINNESOTA STATE<br/>STATUTES.</p> <p>The letter in the left column is used for<br/>tracking purposes and reflects the scope<br/>and level issued pursuant to 144G.31<br/>subd. 1, 2, and 3.</p> |  |                                                     |
| 0 250<br>SS=F                                                       | <p>144G.20 Subdivision 1 Conditions</p> <p>(a) The commissioner may refuse to grant a<br/>provisional license, refuse to grant a license as a</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 0 250                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                     |

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 250                                                               | <p>Continued From page 1</p> <p>result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility:</p> <p>(1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules;</p> <p>(2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services;</p> <p>(3) performs any act detrimental to the health, safety, and welfare of a resident;</p> <p>(4) obtains the license by fraud or misrepresentation;</p> <p>(5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter;</p> <p>(6) denies representatives of the department access to any part of the facility's books, records, files, or employees;</p> <p>(7) interferes with or impedes a representative of the department in contacting the facility's residents;</p> <p>(8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1;</p> <p>(9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department;</p> <p>(10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter;</p> <p>(11) refuses to initiate a background study under</p> | 0 250                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 250                                                               | <p>Continued From page 2</p> <p>section 144.057 or 245A.04;<br/>(12) fails to timely pay any fines assessed by the commissioner;<br/>(13) violates any local, city, or township ordinance relating to housing or assisted living services;<br/>(14) has repeated incidents of personnel performing services beyond their competency level; or<br/>(15) has operated beyond the scope of the assisted living facility's license category.<br/>(b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).</p> <p>The findings include:</p> <p>During the entrance conference on July 31, 2023, at 9:52 a.m., licensed assisted living director</p> | 0 250                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 250                                                               | <p>Continued From page 3</p> <p>(LALD)-D stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services.</p> <p>The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]:</p> <ul style="list-style-type: none"><li>- I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17.</li><li>- I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable.</li><li>- Assisted Living Licensure statutes in Minn. Stat. chpt. 144G.</li><li>- Assisted Living Licensure rules in Minnesota Rules, chpt. 4659.</li><li>- Reporting of Maltreatment of Vulnerable Adults.</li><li>- Electronic Monitoring in Certain Facilities.</li><li>- I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which</li></ul> | 0 250                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 250                                                               | <p>Continued From page 4</p> <p>may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices.</p> <p>- I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license.</p> <p>- I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract.</p> <p>- I have examined this application and all</p> | 0 250                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 250                                                               | <p>Continued From page 5</p> <p>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.</p> <p>- I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable.</p> <p>Page five was electronically signed by authorized agent (AA)-H on November 1, 2022.</p> <p>The licensee had an assisted living license issued on January 1, 2023, with an expiration date of December 31, 2023.</p> <p>The licensee failed to ensure the following policies and procedures were developed and/or implemented:</p> <ul style="list-style-type: none"><li>- orientation, training, and competency evaluations of staff, and a process for evaluating staff performance;</li><li>- conducting ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate;</li><li>- orientation to and implementation of the assisted living bill of rights;</li><li>- infection control practices;</li><li>- reminders for medications, treatments, or exercises, if provided;</li><li>- conducting appropriate screenings, or</li></ul> | 0 250                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                         |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 250                                                               | Continued From page 6<br><br>documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; and<br>- medication and treatment management.<br><br>On August 2, 2023, at 3:53 p.m., LALD-D and clinical nurse supervisor (CNS)-C confirmed the licensee provided assisted living with dementia care but failed to implement corresponding policies and procedures, as required.<br><br>As a result of this survey, the following orders were issued 0470, 0480, 0510, 0650, 0660, 0680, 0730, 0800, 0810, 1470, 1500, 1540, 1620, 1640, 1730, 1760, 1820, 1880, 1890, 1940, 1970, 2040, 2090, 2110, 2310, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 250                                                                                                   |                                                                                                                          |  |                                                        |
| 0 470<br>SS=F                                                       | 144G.41 Subdivision 1 Minimum requirements<br><br>(11) develop and implement a staffing plan for determining its staffing level that:<br>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;<br>(ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and<br>(iii) ensures that the facility can respond promptly                                                                                                                                                                                                                                                                                                                                                                                                                             | 0 470                                                                                                   |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 470                                                               | <p>Continued From page 7</p> <p>and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be:</p> <p>(i) awake;</p> <p>(ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time;</p> <p>(iii) capable of communicating with residents;</p> <p>(iv) capable of providing or summoning the appropriate assistance; and</p> <p>(v) capable of following directions;</p> <p>This MN Requirement is not met as evidenced by:</p> <p>Based on observation, interview, and record review, the licensee failed to have a daily work schedule posted in a central location accessible to staff, residents, volunteers, and the public as required and failed to develop and implement a written staffing plan that included an evaluation completed by a registered nurse at least twice a year. This had the potential to affect all residents, staff, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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).</p> | 0 470                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 470                                                               | <p>Continued From page 8</p> <p>The findings include:</p> <p>During the entrance conference on July 31, 2023, at approximately a.m., the surveyor requested the licensee's staffing plan. Licensed assisted living director (LALD)-D stated they believed it was located at the front desk.</p> <p>On July 31, 2023, at 11:15 a.m., during a facility tour, the surveyor observed the licensee lacked a daily staffing schedule posted in a central location.</p> <p>On July 31, 2023, at 11:20 a.m., the surveyor inquired where the staff schedule was posted. Concierge staff (C)-J stated it looked like they did not print it out this week and put it in the binder. The surveyor inquired if the staff schedule was normally kept in the binder under the front desk. (C)-J stated yes, that was where it was normally kept.</p> <p>On July 31, 2023, at 11:25 a.m., the surveyor inquired where the staff schedule was posted. Licensed assisted living director (LALD)-D stated it would be at the front desk however, they did not print it out from the scheduling system. LALD-D then stated they wanted to check another binder in a different location. The surveyor inquired if it would be posted or located in a binder. LALD-D stated it would be located in a binder.</p> <p>On August 1, 2023, at 1:37 p.m., LALD-D stated the licensee used a point system based off resident assessments that determined staffing levels and the licensee did not have a written staffing plan to include an evaluation, completed by a registered nurse at least twice a year. In addition, LALD-D stated they had a policy which described how the licensee determined staffing</p> | 0 470                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 470                                                               | <p>Continued From page 9</p> <p>levels.</p> <p>On August 2, 2023, at 11:59 a.m., clinical nurse supervisor (CNS)-C stated a computer program would generate the staffing level needed to care for the resident.</p> <p>1.The licensee's Staffing - Direct policy dated June 29, 2023, read, "The RCD [resident care director] must develop and implement a written staffing plan that provides an adequate number of qualified direct-care team members to meet the residents' needs 24 hours a day, seven days a week. When developing a direct care staffing plan, the ED/RCD must ensure that staffing levels are adequate to address the following:</p> <ul style="list-style-type: none"><li>a. Each resident's needs, as identified in the resident's service plan and assisted living contract;</li><li>b. Each resident's acuity level, as determined by the most recent assessment or individualized review;</li><li>c. The ability of team members to timely meet the residents' scheduled and reasonably foreseeable unscheduled needs given the physical layout of the community premises;</li><li>d. Whether the community has a secured dementia care unit; and</li><li>e. Staff experience, training, and competency.</li></ul> <p>2. The RCD will develop and implement a staffing plan for determining the community's staffing level that:</p> <ul style="list-style-type: none"><li>a. Includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the community."<p>In addition, the policy indicated the daily work schedule would be posted in a central location in each building of a community or campus, accessible to team members, residents,</p></li></ul> | 0 470                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                         |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 470                                                               | Continued From page 10<br><br>volunteers, and the public.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7)<br>days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 0 470                                                                                                   |                                                                                                                          |  |                                                        |
| 0 480<br>SS=F                                                       | <b>144G.41 Subd 1 (13) (i) (B) Minimum<br/>requirements</b><br><br>(13) offer to provide or make available at least the<br>following services to residents:<br>(B) food must be prepared and served according<br>to the Minnesota Food Code, Minnesota Rules,<br>chapter 4626; and<br><br>This MN Requirement is not met as evidenced<br>by:<br>Based on observation, interview, and record<br>review, the licensee failed to ensure food was<br>prepared according to the Minnesota Food Code.<br>This had the potential to affect all residents.<br><br>This practice resulted in a level two violation (a<br>violation that did not harm a resident's health or<br>safety but had the potential to have harmed a<br>resident's health or safety, but was not likely to<br>cause serious injury, impairment, or death), and<br>was issued at a widespread scope (when<br>problems are pervasive or represent a systemic<br>failure that has affected or has potential to affect<br>a large portion or all of the residents).<br><br>The findings include:<br><br>Please refer to the additional documentation<br>included in the Food and Beverage Establishment<br>Inspection Reports, dated August 1, 2023. | 0 480                                                                                                   |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                         |                                                                                                                          |                                                        |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 480                                                               | Continued From page 11                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 0 480                                                                                                   |                                                                                                                          |                                                        |
|                                                                     | TIME PERIOD FOR CORRECTION: Twenty-one<br>(21) days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                         |                                                                                                                          |                                                        |
| 0 510<br>SS=F                                                       | <p><b>144G.41 Subd. 3 Infection control program</b></p> <p>(a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.</p> <p>(b) The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.</p> <p>(c) The facility must maintain written evidence of compliance with this subdivision.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complied with accepted health care, medical and nursing standards for infection control related to dropped medication and hand hygiene for three of four employees (unlicensed personnel (ULP)-B, ULP-E, ULP-G).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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).</p> | 0 510                                                                                                   |                                                                                                                          |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                         |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 510                                                               | <p>Continued From page 12</p> <p>The findings include:</p> <p><b>DROPPED MEDICATION</b></p> <p><b>ULP-E</b></p> <p>On August 1, 2023, at 7:31 a.m., during medication administration observation, the surveyor observed R3 remove one tablet of aspirin 81 milligram chewable and once capsule of Ared 2 formula capsule from mouth and place on the dining room table. Unlicensed personnel (ULP)-E picked the medications up off the table and placed them back into the medication cup and returned to the medication cart. ULP-E crushed the aspirin, cut open the Areds 2 capsule with scissors, placed medications into the same medication cup, poured chocolate syrup onto the medication, and administered the contaminated medication to R3.</p> <p>On August 1, 2023, at 8:00 a.m., ULP-E stated if a medication dropped on the floor, they would place the medication in an envelope and give it to the nurse to destroy. The surveyor inquired what ULP-E would do if a medication fell onto a table or other contaminated surface. ULP-E stated they would administer medication if it fell on a table because they sanitize the tables when they arrive to work.</p> <p><b>ULP-B</b></p> <p>On August 2, 2023, at 7:31 a.m., the surveyor observed R16 drop one unidentified medication on the ground and state to ULP-B, "It is ok, just give it to me." ULP-B picked up the unidentified medication and placed it in R16's hand. R16 then swallowed the contaminated medication that</p> | 0 510                                                                                                   |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 510                                                               | <p>Continued From page 13</p> <p>dropped on the floor.</p> <p>On August 2, 2023, at 7:54 a.m., ULP-B stated if a medication dropped onto the floor, they would give it to the nurse. The surveyor inquired why they administered R16's medication after it was on the floor. ULP-B stated because R16 said it was ok.</p> <p>On August 2, 2023, at 12:01 p.m., clinical nurse supervisor (CNS)-C stated if a medication dropped the ULP should contact a nurse, provide the nurse the medication, the nurse would destroy the medication, and reorder the medication from the pharmacy.</p> <p>HAND HYGIENE</p> <p>ULP-G</p> <p>On August 2, 2023, at 7:18 a.m., the surveyor observed ULP-G providing cares to R1. ULP-G washed their hands and donned (put on) gloves. ULP-G removed R1's soiled brief (adult diaper) and cleaned R1's perineal (peri) area (skin in and around the genitals and anus) using wet wipes. ULP-G disposed of the wipes and soiled brief in the garbage and did not doff (remove) their gloves or perform hand hygiene. ULP-G continued performing cares with soiled gloves touching R1's clothing and slippers as they got R1 dressed, transferred R1 to their wheelchair (w/c), made R1's bed, brushed R1's hair, filled R1's cup with water for R1 to drink, applied toothpaste to R1's toothbrush, assisted R1 with brushing their teeth and prepared a wet washcloth and used it to wipe R1's face. ULP-G doffed their soiled gloves and performed hand hygiene after they completed R1's cares.</p> | 0 510                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                         |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 510                                                               | <p>Continued From page 14</p> <p>On August 2, 2023, at 7:37 a.m., the surveyor asked ULP-G if they had changed their gloves or performed hand hygiene after providing a brief change and peri cares for R1, ULP-G stated they had not but should have. ULP-G stated they were trained to doff soiled gloves after peri cares and to perform hand hygiene.</p> <p>On August 2, 2023, at 11:30 a.m., business office coordinator (BOC)-K provided ULP-G's training transcript and stated ULP-G's employee record lacked documentation of infection control training.</p> <p>On August 2, 2023, at 11:54 a.m., CNS-C stated ULP-G should have doffed their gloves and performed hand hygiene after performing peri cares for R1. CNS-C stated they did not work for the licensee when ULP-G was hired so was unsure if it had been completed or not, and they would address ULP-G's infection control training immediately.</p> <p>The licensee provided a Team Member Hand Hygiene skills checklist dated 2020, which read:<br/>" State when handwashing is required:<br/>o Before and after contact with a resident<br/>o When coming into contact with blood or body fluids<br/>o After removing gloves<br/>o After using the bathroom<br/>o After coughing, sneezing, or blowing your nose<br/>o After touching an animal<br/>o Before and after serving food<br/>o After handling or touching garbage<br/>o When hands are visibly soiled or dirty."</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p> | 0 510                                                                                                   |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                         |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 650<br>SS=F                                                       | <p><b>144G.42 Subd. 8 Employee records</b></p> <p>(a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information:</p> <p>(1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;</p> <p>(2) records of orientation, required annual training and infection control training, and competency evaluations;</p> <p>(3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;</p> <p>(4) documentation of annual performance reviews that identify areas of improvement needed and training needs;</p> <p>(5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and</p> <p>(6) documentation of the background study as required under section 144.057.</p> <p>This MN Requirement is not met as evidenced by:</p> <p>Based on interview and record review, the licensee failed to ensure employee records contained the required content for four of four employees (licensed practical nurse (LPN)-A, unlicensed personnel (ULP)-B, ULP-E, ULP-G).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive</p> | 0 650                                                                                                   |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 650                                                               | <p>Continued From page 16</p> <p>or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>LPN-A<br/>LPN-A began employment with the licensee April 28, 2022, to provide oversight to unlicensed personnel and provide direct services to residents.</p> <p>LPN-A's employee record lacked an annual performance review.</p> <p>ULP-B<br/>ULP-B was hired July 13, 2020, to provide direct cares to residents and was observed providing direct cares to residents on July 31, 2023.</p> <p>ULP-B's employee record lacked the following documentation:<br/>-annual performance reviews; and<br/>-job description.</p> <p>ULP-E<br/>ULP-E was hired April 21, 2023, to provide direct cares to residents and was observed administering medications to residents on July 31 and August 2, 2023.</p> <p>ULP-E's employee record lacked an annual performance review.</p> <p>Additionally, ULP-E's employee record lacked the following documentation of required training:<br/>-documentation requirements for all services provided;<br/>-reports of changes in the resident's condition to the supervisor designated by the facility;</p> | 0 650                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                 |                                                                                                                          |  |                                              |
|--------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>23982                                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>08/02/2023 |
| NAME OF PROVIDER OR SUPPLIER<br><br>SUNRISE OF GOLDEN VALLEY |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br>4950 OLSON MEMORIAL HIGHWAY<br>GOLDEN VALLEY, MN 55422 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 0 650                                                        | Continued From page 17<br><br>-basic infection control, including blood-borne pathogens;<br>- maintenance of a clean and safe environment;<br>-appropriate and safe techniques in personal hygiene and grooming, including:<br>(i) hair care and bathing;<br>(ii) care of teeth, gums, and oral prosthetic devices;<br>(iii) care and use of hearing aids; and<br>(iv) dressing and assisting with toileting;<br>-training on the prevention of falls;<br>-standby assistance techniques and how to perform them;<br>-medication, exercise, and treatment reminders;<br>-basic nutrition, meal preparation, food safety, and assistance with eating;<br>-preparation of modified diets as ordered by a licensed health professional;<br>-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;<br>-awareness of confidentiality and privacy;<br>-understanding appropriate boundaries between staff and residents and the resident's family;<br>-procedures to use in handling various emergency situations;<br>-awareness of commonly used health technology equipment and assistive devices;<br>-observing, reporting, and documenting resident status;<br>-basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel;<br>-reading and recording temperature, pulse, and respirations of the resident;<br>- recognizing physical, emotional, cognitive, and developmental needs of the resident;<br>-safe transfer techniques and ambulation; | 0 650                                                                                           |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                 |                                                                                                                          |                          |                                              |
|--------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>23982 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br>08/02/2023 |
| NAME OF PROVIDER OR SUPPLIER<br><br>SUNRISE OF GOLDEN VALLEY |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>4950 OLSON MEMORIAL HIGHWAY<br>GOLDEN VALLEY, MN 55422                          |                          |                                              |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                              |
| 0 650                                                        | Continued From page 18<br><br>-range of motioning and positioning; and<br>-administering medications or treatments as required.<br><br>ULP-G<br>ULP-G was hired May 15, 2023, to provide direct cares to residents and was observed providing direct cares to residents on July 31 and August 2, 2023.<br><br>ULP-G's employee record lacked the following documentation of required training:<br>-documentation requirements for all services provided;<br>- reports of changes in the resident's condition to the supervisor designated by the facility;<br>-basic infection control, including blood-borne pathogens;<br>- maintenance of a clean and safe environment;<br>-appropriate and safe techniques in personal hygiene and grooming, including:<br>(i) hair care and bathing;<br>(ii) care of teeth, gums, and oral prosthetic devices;<br>(iii) care and use of hearing aids; and<br>(iv) dressing and assisting with toileting;<br>-training on the prevention of falls;<br>-standby assistance techniques and how to perform them;<br>-medication, exercise, and treatment reminders;<br>-basic nutrition, meal preparation, food safety, and assistance with eating;<br>-preparation of modified diets as ordered by a licensed health professional;<br>-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;<br>-awareness of confidentiality and privacy;<br>-understanding appropriate boundaries between | 0 650                                                           |                                                                                                                          |                          |                                              |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                         |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 650                                                               | <p>Continued From page 19</p> <p>staff and residents and the resident's family;<br/>-procedures to use in handling various<br/>emergency situations;<br/>-awareness of commonly used health technology<br/>equipment and assistive devices;<br/>-observing, reporting, and documenting resident<br/>status;<br/>-basic knowledge of body functioning and<br/>changes in body functioning, injuries, or other<br/>observed changes that must be reported to<br/>appropriate personnel;<br/>-reading and recording temperature, pulse, and<br/>respirations of the resident;<br/>- recognizing physical, emotional, cognitive, and<br/>developmental needs of the resident;<br/>-safe transfer techniques and ambulation;<br/>-range of motioning and positioning; and<br/>-administering medications or treatments as<br/>required.</p> <p>On July 31, 2023, at 9:45 a.m., during entrance<br/>conference, licensed assisted living director<br/>(LALD)-D stated they were aware of the required<br/>content for employee records.</p> <p>On August 1, 2023, at 12:07 p.m., business office<br/>coordinator (BOC)-K stated all of ULP-B's<br/>employee records had been provided and if the<br/>annual performances and job description for<br/>ULP-B could not be located by the surveyor then<br/>they must not have been completed.</p> <p>On August 2, 2023, at 11:30 a.m., BOC-K stated<br/>they provided everything they had for employee<br/>records and if it wasn't provided then they either<br/>didn't have it or it wasn't completed.</p> <p>On August 2, 2023, at 12:02 p.m., clinical nurse<br/>supervisor (CNS)-C stated they were unaware of<br/>what content was required in the employee</p> | 0 650                                                                                                   |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                         |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 650                                                               | Continued From page 20<br><br>record.<br><br>The licensee's Team Member Competency and Performance Evaluation policy dated December 13, 2021, indicated a team member competency and performance evaluation is completed in compliance with Minnesota Statutes Chapter 144G.42 § 8(2); 144G.60 § 2; 144G.61, and MN Department of Health, Rules Governing Assisted Living Facilities Chapter 4659 §4659.0190 for Minnesota Sunrise Senior Living communities.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days                                                                                                                                                                                                                                                                               | 0 650                                                                                                   |                                                                                                                          |  |                                                        |
| 0 660<br>SS=F                                                       | 144G.42 Subd. 9 Tuberculosis prevention and control<br><br>(a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.<br>(b) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by: | 0 660                                                                                                   |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 660                                                               | <p>Continued From page 21</p> <p>Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test and a completed health history and symptom screening for three of four employees (licensed practical nurse (LPN)-A, unlicensed personnel (ULP)-B, ULP-E). In addition, the licensee failed to complete a facility TB risk assessment.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On July 31, 2023, at 9:45 a.m., during the entrance conference, the surveyor requested the licensee's facilities TB risk assessment.</p> <p>On August 1, 2023, at 1:40 p.m., licensed assisted living director (LALD)-D stated the facility TB risk assessment was "being completed right now." In addition, LALD-D stated they had not seen the the facility TB Risk Assessment Worksheet for Health Care Settings Licensed by Minnesota Department of Health (MDH) form prior to the surveyor showing them because they were not required in the previous state they worked for.</p> <p>LPN-A</p> | 0 660                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                         |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b>                                  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 660                                                               | <p>Continued From page 22</p> <p>LPN-A began employment with the licensee April 28, 2022, to provide oversight to unlicensed personnel and provide direct services to residents.</p> <p>LPN-A's employee record lacked a completed health history and symptom screening.</p> <p>On August 1, 2023, at 11:55 a.m., business office manager (BOC)-K stated they were unable to locate the symptom screening. In addition, BOC-K stated they believed LPN-A's record did not exist prior to BOC-K's employment and they had been recreating files since their date of hire.</p> <p>ULP-B<br/>ULP-B was hired July 13, 2020, to provide direct cares to residents and was observed providing direct cares to residents on July 31, 2023.</p> <p>ULP-B's employee record lacked the following documentation:<br/>-completed health history and symptom screening; and<br/>-baseline TB test screening via two-step TST or blood test.</p> <p>ULP-E<br/>ULP-E was hired April 21, 2023, to provide direct cares to residents and was observed administering medications to residents on July 31 and August 2, 2023.</p> <p>ULP-E's employee record lacked the following documentation:<br/>-completed health history and symptom screening; and<br/>-baseline TB test screening via two-step TST or blood test.</p> | 0 660                                                                                                   |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 660                                                               | <p>Continued From page 23</p> <p>On August 2, 2023, at 12:03 p.m., clinical nurse supervisor (CNS)-C stated employees should receive a symptom screening and a Mantoux upon hire.</p> <p>The CDC Morbidity and Mortality Weekly Report (MMWR) Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel dated May 17, 2019, indicated all health personnel should have a baseline screening and an individual risk assessment, which is necessary for interpreting any test result.</p> <p>The Facility Tuberculosis (TB) Risk Assessment Instructions and Worksheet for Health Care Settings Licensed by the Minnesota Department of Health (MDH) dated June 2023, available on MDH's Frequently Asked Questions page indicated facilities should perform a facility risk assessment on an annual basis.</p> <p>The licensee's Tuberculosis Screening - Team Members policy dated September 3, 2021, indicated the executive director (ED) or designee would facilitate the TB screening of team members as outlined in the infection prevention and control program using a two-step TST or a TB blood test and follow the most current TB infection control guidelines issued by the CDC. In addition, ED and the resident care director (RCD) would complete a risk assessment annually at the facility.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p> | 0 660                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 680                                                               | Continued From page 24                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 0 680                                                                  |                                                                                                                          |  |                                                     |
| 0 680<br>SS=F                                                       | <p><b>144G.42 Subd. 10 Disaster planning and emergency preparedness</b></p> <p>(a) The facility must meet the following requirements:<br/>(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;<br/>(2) post an emergency disaster plan prominently;<br/>(3) provide building emergency exit diagrams to all residents;<br/>(4) post emergency exit diagrams on each floor; and<br/>(5) have a written policy and procedure regarding missing residents.<br/>(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.<br/>(c) The facility must meet any additional requirements adopted in rule.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted living with dementia license.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or</p> | 0 680                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                         |                                                                                                                          |                                                        |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 680                                                               | <p>Continued From page 25</p> <p>safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>The licensee's emergency disaster preparedness plan lacked evidence of the following required content:</p> <ul style="list-style-type: none"> <li>- quarterly review of missing resident policy;</li> <li>- annual review of EPP;</li> <li>- strategies for addressing facility surges/shortages;</li> <li>- policy and/or procedure for system to track the location of on-duty staff and sheltered residents;</li> <li>- policy and procedure for medical documents;</li> <li>- policy and/or procedure to address role of facility under a waiver declared by the secretary in accordance with section 1135 of the act; and</li> <li>- family notification.</li> </ul> <p>On August 1, 2023, at 1:54 p.m., licensed assisted living director (LALD)-D verified the EPP lacked content listed. LALD-D stated they updated the EPP in April 2023 but did not have documentation to show this occurred. In addition, LALD-D stated the missing resident policy should be reviewed annually with the EPP and they were unfamiliar of the licensee's role under waiver declared by secretary 1135.</p> <p>The licensee's Emergency Preparedness Plan-Appendix Z Compliance dated February 17, 2022, indicated the licensee's EPP would be aligned with the Centers for Medicare and Medicaid Services (CMS) State Operation</p> | 0 680                                                                                                   |                                                                                                                          |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                         |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 680                                                               | Continued From page 26<br><br>Manual Appendix Z.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one<br>(21) days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 0 680                                                                                                   |                                                                                                                          |  |                                                        |
| 0 730<br>SS=F                                                       | <b>144G.43 Subd. 3</b> Contents of resident record<br><br>Contents of a resident record include the<br>following for each resident:<br>(1) identifying information, including the resident's<br>name, date of birth, address, and telephone<br>number;<br>(2) the name, address, and telephone number of<br>the resident's emergency contact, legal<br>representatives, and designated representative;<br>(3) names, addresses, and telephone numbers of<br>the resident's health and medical service<br>providers, if known;<br>(4) health information, including medical history,<br>allergies, and when the provider is managing<br>medications, treatments or therapies that require<br>documentation, and other relevant health<br>records;<br>(5) the resident's advance directives, if any;<br>(6) copies of any health care directives,<br>guardianships, powers of attorney, or<br>conservatorships;<br>(7) the facility's current and previous<br>assessments and service plans;<br>(8) all records of communications pertinent to the<br>resident's services;<br>(9) documentation of significant changes in the<br>resident's status and actions taken in response to<br>the needs of the resident, including reporting to<br>the appropriate supervisor or health care<br>professional;<br>(10) documentation of incidents involving the | 0 730                                                                                                   |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 730                                                               | <p>Continued From page 27</p> <p>resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;</p> <p>(11) documentation that services have been provided as identified in the service plan;</p> <p>(12) documentation that the resident has received and reviewed the assisted living bill of rights;</p> <p>(13) documentation of complaints received and any resolution;</p> <p>(14) a discharge summary, including service termination notice and related documentation, when applicable; and</p> <p>(15) other documentation required under this chapter and relevant to the resident's services or status.</p> <p>This MN Requirement is not met as evidenced by:</p> <p>Based on interview and record review, the licensee failed to ensure the resident record included documentation of all services provided for two of four residents (R1, R2). In addition, based on interview and record review, the licensee failed to complete a discharge summary for one of one resident (R5) discharged from the licensee.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>R1</p> | 0 730                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 730                                                               | <p>Continued From page 28</p> <p>R1's Service Plan dated June 23, 2023, indicated R1 received services for housekeeping, laundry, bathing, dining, bathroom assistance, dressing, mobility, transportation, incontinence cares, behavior management, and medication administration.</p> <p>R1's Documentation Survey Report v2 for July 2023, lacked documentation for 32 services provided.</p> <p>R2</p> <p>R2's Service Plan dated September 27, 2021, indicated R2 received services for housekeeping, laundry, dining, bathing, toileting, dressing, grooming, meals, and medication administration.</p> <p>R2's Documentation Survey Report v2 for July 2023, lacked documentation for 62 services provided.</p> <p>On August 2, 2023, at 1:03 p.m., clinical nurse supervisor (CNS)-C stated the expectation was for every service to be documented on, there shouldn't be blank spots on the documentation report. If a resident refused a service or if a service was missed there should still be documentation of why the service was not provided. CNS-C stated the system does alert them when documentation had been missed and they should follow up on it, "but that doesn't always happen."</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p> | 0 730                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                         |                                                                                                                          |                                                        |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 800                                                               | Continued From page 29                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 0 800                                                                                                   |                                                                                                                          |                                                        |
| 0 800<br>SS=F                                                       | <p><b>144G.45 Subd. 2 (a) (4) Fire protection and physical environment</b></p> <p>(4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation and interview, the licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On August 01, 2023, at approximately 10:00 a.m., survey staff toured the facility with the Maintenance Coordinator (MC)-F. During the facility tour, survey staff observed the following:</p> <p>In the restroom on the first floor, it was observed that two light bulbs in wall mounted light fixture were burned.</p> | 0 800                                                                                                   |                                                                                                                          |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                         |                                                                                                                          |                                                        |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 800                                                               | Continued From page 30<br><br>In resident unit 312, it was observed that the light bulb over the vanity in the bathroom was burned.<br><br>In the restroom and open nurse station on the second floor, it was observed that black-colored dust was on the supply air grilles.<br><br>In resident unit 115, it was observed that the wall had a large hole in the sheetrock, and it was loosely covered with a sheetrock patch. This wall is part of a fire barrier and is required to maintain fire resistance integrity.<br><br>Review of the available maintained record, it was also observed that the fire sprinkler system had not had an official annual maintenance inspection since 6/28/2021. MC-F provided a record of the in-house fire alarm test conducted on 8/30/2022 by the previous maintenance coordinator, but he was not able to confirm if the facility conducted an annual inspection. An annual maintenance inspection of the fire sprinkler system is required. During the interview, MC-F stated that the record would be provided via email as a follow-up, but no documentation has been provided by follow-up email.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 800                                                                                                   |                                                                                                                          |                                                        |
| 0 810<br>SS=F                                                       | 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 0 810                                                                                                   |                                                                                                                          |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                         |                                                                                                                          |                                                        |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 810                                                               | <p>Continued From page 31</p> <p>(2) employee actions to be taken in the event of a fire or similar emergency;</p> <p>(3) fire protection procedures necessary for residents; and</p> <p>(4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.</p> <p>(c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.</p> <p>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.</p> <p>(e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.</p> <p>(f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to develop a fire safety and evacuation plan with the required elements; failed to provide required employee training on fire safety and evacuation and failed to provide training to residents capable of assisting in their own evacuation. This had the potential to affect all staff, residents, and visitors.</p> | 0 810                                                                                                   |                                                                                                                          |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 810                                                               | <p>Continued From page 32</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>Findings include:</p> <p>An interview and record review were conducted on August 01, 2023, at approximately 12:00 p.m. with the Maintenance Coordinator (MC)-F on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility.</p> <p>On the facility tour with the MC-F, it was observed that the posted fire safety and evacuation plans plan did not show the location and number of resident rooms throughout the facility. This deficient condition was visually verified by MC-F accompanying the tour.</p> <p>Record review of the available documentation indicated that employees did not receive training twice per year after initial hire. During the interview, MC-F stated that the licensee provided annual training to employees, but not twice per year after the initial hire, on the fire safety and evacuation plan, as required by statute. During the interview, MC-F stated that the facility provided only one fire safety training in August 2022 and confirmed that there was no further documented training for the staff on the fire safety and evacuation plan as required by statute.</p> <p>Record review of the available documentation did</p> | 0 810                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 810                                                               | Continued From page 33<br><br>not indicate that the licensee provides annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire to include movement, evacuation, or relocation as required by statute. MC-F verified that there were no further documented resident training for the facility and verified this deficient condition.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 0 810                                                                  |                                                                                                                          |  |                                                     |
| 01470<br>SS=F                                                       | 144G.63 Subd. 2 Content of required orientation<br><br>(a) The orientation must contain the following topics:<br>(1) an overview of this chapter;<br>(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;<br>(3) handling of emergencies and use of emergency services;<br>(4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);<br>(5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;<br>(7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;<br>(8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of | 01470                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01470                                                               | <p>Continued From page 34</p> <p>Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure.</p> <p>(b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:</p> <p>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;</p> <p>(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or</p> <p>(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for three of three employees (licensed practical nurse (LPN)-A, unlicensed personnel (ULP)-B, ULP-E).</p> | 01470                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01470                                                               | <p>Continued From page 35</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>LPN-A<br/>LPN-A began employment with the licensee April 28, 2022, to provide oversight to unlicensed personnel and provide direct services to residents.</p> <p>ULP-B<br/>ULP-B began employment with the licensee July 13, 2020, to provide direct cares to residents.</p> <p>ULP-E<br/>ULP-E began employment with the licensee April 21, 2021, to provide direct cares to residents.</p> <p>LPN-A, ULP-B and ULP-E's employee records lacked evidence of orientation to assisted living regulations (144G.63, Sub. 2) effective August 1, 2021, for the following:</p> <ul style="list-style-type: none"><li>- an overview of this assisted living statutes;</li><li>- a review of the types of assisted living services the employee will be providing and the facility's category of licensure; and</li><li>- the assisted living bill of rights.</li></ul> <p>On August 1, 2023, business office coordinator (BOC)-K provided the surveyor an undated document titled A Guide to Home Care Services which reviewed an overview of basic and comprehensive licensure, a review of services</p> | 01470                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                         |                                                                                                                          |                                                        |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 01470                                                               | Continued From page 36<br><br>available through state regulated home care providers, and home care bill of rights. BOC-K stated they reviewed this document with all new employees. The surveyor inquired if they trained on the above requirements of assisted living. BOC-K stated they trained on a review of basic home care license provider, a review of comprehensive home care license provider, services available through state regulated home care providers, and the home care bill of rights.<br><br>The licensee's Team Member Training policy dated August 19, 2021, indicated all team members providing and supervising direct services would receive an overview of MN assisted living regulations, assisted living bill of rights, and a review of assisted living types of services the team member would provide and the provider's category of licensure.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01470                                                                                                   |                                                                                                                          |                                                        |
| 01500<br>SS=E                                                       | 144G.63 Subd. 5 Required annual training<br><br>(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:<br>(1) training on reporting of maltreatment of vulnerable adults under section 626.557;<br>(2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;                                                                                                                                                                                                                                                                                                                                                                       | 01500                                                                                                   |                                                                                                                          |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01500                                                               | <p>Continued From page 37</p> <p>(3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;</p> <p>(4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;</p> <p>(5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and</p> <p>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.</p> <p>(b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:</p> <p>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;</p> <p>(2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or</p> <p>(3) information about strategies and technology that may enhance communication and</p> | 01500                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                         |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01500                                                               | <p>Continued From page 38</p> <p>involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment in all required training topics for two of three employees (unlicensed personnel (ULP)-B, ULP-E).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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).</p> <p>The findings include:</p> <p>ULP-B<br/>ULP-B was hired July 13, 2020, to provide direct cares to residents and observed providing direct cares to residents on July 31, 2023.</p> <p>ULP-B's employee record lacked the following required annual trainings:</p> <ul style="list-style-type: none"><li>- reporting maltreatment and abuse;</li><li>- assisted living bill of rights;</li><li>- infection control techniques;</li><li>- effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with</li></ul> | 01500                                                                                                   |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                         |                                                                                                                          |                                                        |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 01500                                                               | <p>Continued From page 39</p> <p>residents who have dementia, Alzheimer's disease, or related disorders;<br/>- review of policies and procedures relating to the provision of assisted living services and how to implement them; and<br/>- principles of person-centered planning.</p> <p>ULP-E<br/>ULP-E was hired April 21, 2021, to provide direct cares to residents and observed administering medications to residents on July 31 and August 2, 2023.</p> <p>ULP-E's employee record lacked the following required annual trainings:<br/>- reporting maltreatment and abuse;<br/>- assisted living bill of rights;<br/>- infection control techniques;<br/>- 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;<br/>- review of policies and procedures relating to the provision of assisted living services and how to implement them; and<br/>- principles of person-centered planning.</p> <p>The licensee had no record they provided any annual training to ULP-B and ULP-E.</p> <p>On July 31, 2023, at 9:45 a.m., during entrance conference, licensed assisted living director (LALD)-D stated they were aware of the required content for employee records.</p> <p>On August 1, 2023, at 12:07 p.m., business office coordinator (BOC)-K stated all of ULP-B's employee records had been provided and if the annual performances and job description for</p> | 01500                                                                                                   |                                                                                                                          |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                         |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01500                                                               | Continued From page 40<br><br>ULP-B could not be located by the surveyor then they must not have been completed.<br><br>On August 2, 2023, at 11:30 a.m., BOC-K stated they provided everything they had for employee records and if it wasn't provided then they either didn't have it or it wasn't completed.<br><br>On August 2, 2023, at 12:02 p.m., clinical nurse supervisor (CNS)-C stated they were unaware of what content was required in the employee record.<br><br>The licensee's 2023 Annual Training Calendar: Minnesota dated April 2023, indicated infection control essential principles, essentials of resident rights, dementia care supporting families, an overview of quality dementia care and abuse and neglect prevention were required annual trainings. It did not indicate the number of required hours of annual training to be provided.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01500                                                                                                   |                                                                                                                          |  |                                                        |
| 01540<br>SS=E                                                       | <b>144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED</b><br><br>(3) for assisted living facilities with dementia care, direct-care employees 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, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 01540                                                                                                   |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01540                                                               | <p>Continued From page 41</p> <p>dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to ensure two hours of required annual dementia care training was completed for two of three direct-care employees (unlicensed personnel (ULP)-B) and ULP-E).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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).</p> <p>The findings include:</p> <p>ULP-B<br/>ULP-B was hired July 13, 2020, to provide direct cares to residents and was observed providing direct cares to residents on July 31, 2023.</p> <p>ULP-E<br/>ULP-E was hired April 21, 2021, to provide direct cares to residents and was observed administering medications to residents on July 31</p> | 01540                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01540                                                               | <p>Continued From page 42<br/>and August 2, 2023.</p> <p>ULP-B and ULP-E's employee records lacked the required two hours of annual dementia training. Both employee's records contained zero hours of dementia care training in the past year.</p> <p>On July 31, 2023, at 9:45 a.m., during entrance conference, licensed assisted living director (LALD)-D stated they were aware of the required content for employee records.</p> <p>On August 2, 2023, at 11:30 a.m., business office coordinator (BOC)-K stated they provided everything they had for employee records and if it wasn't provided then they either didn't have it or it wasn't completed.</p> <p>On August 2, 2023, at 12:02 p.m., clinical nurse supervisor (CNS)-C stated they were unaware of what content was required in the employee record.</p> <p>The licensee's 2023 Annual Training Calendar: Minnesota dated April 2023, indicated dementia care supporting families and an overview of quality dementia care were required annual trainings.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p> | 01540                                                                  |                                                                                                                          |  |                                                     |
| 01620<br>SS=E                                                       | <p>144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring</p> <p>(c) Resident reassessment and monitoring must be conducted no more than 14 calendar days</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 01620                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                         |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01620                                                               | <p>Continued From page 43</p> <p>after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.</p> <p>(d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.</p> <p>(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a 14-day assessment no more than 14 calendar days after initiation of services for one of four residents (R1). In addition, the licensee failed to ensure the RN conducted 90-days assessments thereafter for two of four residents (R1, R2).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited</p> | 01620                                                                                                   |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                         |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b>                                  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01620                                                               | <p>Continued From page 44</p> <p>number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).</p> <p>The findings include:</p> <p>R1<br/>R1 was admitted to the licensee on March 30, 2023. R1's service plan dated June 23, 2023, indicated R1 received services for incontinence, laundry, housekeeping, medication management, dressing, and meals.</p> <p>R1's MN 3.0 SEHA 14-day RN assessment was not completed until April 15, 2023, which was 2 days past the 14-calendar day requirement.</p> <p>R1's record lacked a 90-day assessment which was due to be completed by July 12, 2023.</p> <p>R2<br/>R2 was admitted to the licensee on September 27, 2021. R2's service plan dated September 27, 2021, indicated R2 received services for bathing assistance, laundry, housekeeping, medication management, dressing, and housekeeping.</p> <p>R2's record included R2's MN 3.0 SEHA 90- day RN assessments for May 2, 2022, and October 29, 2022. The October 2022 assessment was 90 days past due. The next 90-day assessment after October 29, 2022, was due by January 27, 2023, but was not completed until May 5, 2023, which was 98 days past due.</p> <p>On July 31, 2023, at 9:30 a.m., clinical nurse supervisor (CNS)-C stated they believed RN assessments should be completed every 14 days, then every six months and with change of conditions (COC) thereafter.</p> | 01620                                                                                                   |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                         |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01620                                                               | Continued From page 45<br><br>On August 1, 2023, at 11:38 a.m., CNS-C stated they were aware of the 14-day nursing assessment requirements and R1's was late but was completed prior to their employment. CNS-C stated they thought ongoing assessments for residents were required every 60 days then changed their answer to every six months. Surveyor explained they were due every 90 days.<br><br>The licensee's Resident Assessments, Monitoring & Supervisory Visits policy dated August 19, 2021, indicated, "The RCD/RN will monitor and reassess the resident during a Supervisory Visit no more than 14 days after move-in, and thereafter within 90 days from the date of the last assessment. The RCD/RN will determine the frequency of monitoring or reassessment visits ongoing based on the resident's needs and the complexity of the services needed, which may be more often, but at a minimum not to exceed every 90 days.<br><br>No additional information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01620                                                                                                   |                                                                                                                          |  |                                                        |
| 01640<br>SS=E                                                       | 144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to<br><br>(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.<br>(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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 01640                                                                                                   |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01640                                                               | <p>Continued From page 46</p> <p>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.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to ensure current service plans included a signature or other authentication by the licensee or resident to document agreement on the services to be provided for three of four residents (R1, R2, R5).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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).</p> <p>The findings include:</p> <p>R1<br/>R1 was admitted to the licensee on March 30, 2023, and began receiving assisted living</p> | 01640                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01640                                                               | <p>Continued From page 47</p> <p>services.</p> <p>R1's unsigned service plan dated June 23, 2023, indicated R1 received services for incontinence, laundry, housekeeping, medication management, dressing, and meals.</p> <p>On August 2, 2023, at 7:18 a.m., the surveyor observed unlicensed personnel (ULP)-G provide activities of daily living (ADL) cares for R1. On August 2, 2023, at 7:40 a.m., the surveyor observed ULP-E administer medications to R1.</p> <p>R1's record lacked a signed service plan.</p> <p>R2</p> <p>R2 was admitted to the licensee on September 27, 2021, and began receiving assisted living services.</p> <p>R2's signed service plan dated September 27, 2021, indicated R2 received services for bathing assistance, laundry, housekeeping, medication management, dressing, and housekeeping.</p> <p>On July 31, 2023, at 11:20 a.m., the surveyor observed ULP-B perform blood glucose monitoring on R2.</p> <p>R2's record also contained an unsigned service plan dated June 23, 2023, which had multiple changes in services from the September 27, 2021, service plan.</p> <p>R5</p> <p>R5 admitted to the licensee on April 17, 2023, and began receiving assisted living services.</p> <p>On August 2, 2023, at 7:47 a.m., the surveyor observed ULP-B perform blood glucose</p> | 01640                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                         |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01640                                                               | <p>Continued From page 48</p> <p>monitoring on R5.</p> <p>R5's unsigned service plan with last date reviewed May 10, 2023, indicated R5 received assistance with medication management including administration of insulin, meals, transportation, bathing, laundry.</p> <p>On August 1, 2023, via email correspondence at 7:59 p.m., clinical nurse supervisor (CNS)-C stated they were unable to find a signed service plan for R5.</p> <p>On August 2, 2023, at 11:54 a.m., CNS-C stated R2's June 23, 2023, did have multiple changes made since R2's signed September 27, 2023, service plan. CNS-C stated they were having disagreements with the family who did not want to agree to the increased service needs for R2.</p> <p>On August 2, 2023, at 12:06 p.m., CNS-C stated service plans were autogenerated based off the resident assessment and they would update the autogenerated service plan with resident's preferences. CNS-C stated service plans were updated as changes occurred to the resident's needs. In addition, CNS-C stated residents or families were notified of the changes to the service plan and asked to sign the service plan agreement. The surveyor inquired why R5's service plan lacked a signature. CNS-C stated they searched for R5's signed service plan, however, were unable to locate the signature page.</p> <p>On August 2, 2023, at 12:55 p.m., licensed assisted living director (LALD)-D stated they were only slightly aware of R2's service plan situation. LALD-D stated they were currently providing the increased services for R2 but were not billing</p> | 01640                                                                                                   |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                         |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01640                                                               | Continued From page 49<br><br>them for any services not agreed to by the family.<br><br>The licensee's Individualized Service Plans<br>(addendum) dated August 19, 2021, indicated the<br>resident care director (RCD) or the registered<br>nurse (RN) would review change and update the<br>individual service plan (ISP) as needed. In<br>addition, the ISP would be signed by the RCD,<br>RN or licensed health professional and the<br>resident or resident representative documenting<br>agreement on the services to be provided when<br>updated or revised.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one<br>(21) days                                                                                                                                                                                                                                                                                               | 01640                                                                                                   |                                                                                                                          |  |                                                        |
| 01730<br>SS=D                                                       | <b>144G.71 Subd. 5 Individualized medication<br/>management plan</b><br><br>(a) For each resident receiving medication<br>management services, the assisted living facility<br>must prepare and include in the service plan a<br>written statement of the medication management<br>services that will be provided to the resident. The<br>facility must develop and maintain a current<br>individualized medication management record for<br>each resident based on the resident's<br>assessment that must contain the following:<br>(1) a statement describing the medication<br>management services that will be provided;<br>(2) a description of storage of medications based<br>on the resident's needs and preferences, risk of<br>diversion, and consistent with the manufacturer's<br>directions;<br>(3) documentation of specific resident instructions<br>relating to the administration of medications;<br>(4) identification of persons responsible for | 01730                                                                                                   |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01730                                                               | <p>Continued From page 50</p> <p>monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;<br/>(5) identification of medication management tasks that may be delegated to unlicensed personnel;<br/>(6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and<br/>(7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.<br/>(b) The medication management record must be current and updated when there are any changes.<br/>(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for one of four residents (R5).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> | 01730                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                           |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01730                                                               | <p>Continued From page 51</p> <p>The findings include:</p> <p>R5 admitted to the licensee on April 17, 2023, and began receiving assisted living services.</p> <p>R5's diagnosis included type 2 diabetes mellitus with diabetic chronic kidney disease.</p> <p>R5's unsigned service plan, indicated R5 received assistance with medication management including administration of insulin, meals, transportation, bathing, and laundry.</p> <p>R5's individualized medication management record, lacked identification of any specific resident instructions regarding medications the licensee's staff would administer.</p> <p>R5's provider orders signed April 12, 2023, included metronidazole 0.75 percent (%) by topical routine in the morning and in the evening, apply to affected area.</p> <p>R5's medication administration record (MAR) dated August 1, through August 31, 2023, included metronidazole external gel 0.75 % apply to affected area topically two times per day for rash. The order lacked specific instructions on where medication was to be applied.</p> <p>On August 2, 2023, at 7:43 a.m., the surveyor inquired where the unlicensed personnel (ULP) would apply metronidazole external gel 0.75%. ULP-B stated to R5's face. The surveyor inquired if those instructions were written anywhere in R5's medical record. ULP-B stated no because the location of the rash can change however, it is normally on the face or neck.</p> | 01730                                                                     |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                         |                                                                                                                          |                                                        |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 01730                                                               | <p>Continued From page 52</p> <p>On August 2, 2023, 2023, at 7:47 a.m., the surveyor observed ULP-B apply metronidazole external gel 0.75 % to R5's right cheek. The medication package and did not note a location to be applied.</p> <p>On August 2, 2023, at 12:12 p.m., clinical nurse supervisor (CNS)-C stated R5's record did not indicate where to apply the medication however it should be applied to R5's face. In addition, CNS-C stated a topical medication should have the specific location on where to apply the medication which would be located on the MAR and "sometimes" the pharmacy would write it on the prescription label.</p> <p>The licensee's Medication Management policy dated August 19, 2021, indicated when administration of medication is delegated to the ULP the registered nurse (RN) must specified in writing, specific instructions for each resident and document those instructions in the resident's record.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p> | 01730                                                                                                   |                                                                                                                          |                                                        |
| 01760<br>SS=D                                                       | <p><b>144G.71 Subd. 8 Documentation of administration of medication</b></p> <p>Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 01760                                                                                                   |                                                                                                                          |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01760                                                               | <p>Continued From page 53</p> <p>administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to ensure medications were administered as ordered and/or per manufacturer's instructions for one of nine residents (R3).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R3<br/>On August 1, 2023, at 7:19 a.m., the surveyor observed unlicensed personnel (ULP)-E prepare R3's morning medication which included Centrum oral liquid 15 milliliters (ml), aspirin 81 milligrams (mg) chewable, and Areds 2 formula two capsules. ULP-E filled an ungraduated medication cup approximately 50 percent (%) of the way full, and placed the other medication listed above into a separate medication cup. ULP-E locked the computer screen and went to administer medication to R3. The surveyor</p> | 01760                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01760                                                               | <p><b>Continued From page 54</b></p> <p>intervened and inquired how ULP-E knew they were administering 15 ml of Centrum oral liquid without the graduated lines. ULP-B stated, "I am 100 percent sure it is 15" and proceeded to administer the medication to R3. R3 refused two of the nonliquid medication by removing them from their mouth and placing them on the table. ULP-E picked up the medication from the table, placed it back into the medication cup, and returned to the medication cart. ULP-E stated, "this is what I am talking about she [R3] will not take it unless I crush everything. I didn't crush because it did not tell me to and you're here." ULP-E then crushed aspirin 81 mg chewable tablet, cut open two capsules of Areds 2 formula, placed it into a medication cup, and mixed it with chocolate syrup. The surveyor inquired how long they have been preparing R3's medication like this. ULP-E stated they prepared R3 medication like this for the past month because R3 will refuse the medication otherwise. ULP-E took the medication cup and administered the medication to R3.</p> <p>On August 1, 2023, at 8:02 a.m., ULP-E stated they were trained by a RN for medication administration. ULP-E stated capsules had to be opened and poured into a medication cup and whole pills could be crushed.</p> <p>On August 2, 2023, at 12:24 p.m., clinical nurse supervisor (CNS)-C stated if a medication was supposed to be crushed it would give instructions at the top of the tool bar on the electronic medication administration record (EMAR). In addition, ULP were trained to administer medication only if there was instruction to crush and measure liquids with use of a graduated medication cup. CNS-C was unaware staff were crushing and opening medication due to refusals.</p> | 01760                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                         |                                                                                                                          |                                                     |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b>                                  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                            |
| 01760                                                               | Continued From page 55<br><br>The manufacturer's instructions for Areds 2 dated February 25, 2022, recommended capsule be swallowed whole, do not crush, chew, or break it.<br><br>The licensee's Medication Management policy, dated August 19, 2021, indicated when administration of medications is delegated to a ULP the registered nurse (RN) must instruct the ULP in the proper methods to administer the medications, and the ULP must demonstrate the ability to competently follow the procedures.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days                                                                                                                                                                                                                      | 01760                                                                                                   |                                                                                                                          |                                                     |
| 01820<br>SS=D                                                       | <b>144G.71 Subd. 13 Prescriptions</b><br><br>There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of four residents (R2).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number | 01820                                                                                                   |                                                                                                                          |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01820                                                               | <p>Continued From page 56</p> <p>of staff are involved, or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R2 had a diagnosis of type 2 diabetes (DM2).</p> <p>R2's Service Plan signed on September 27, 2021, indicated R2 received services for diabetic medication management.</p> <p>R2's paper records included a Novolog insulin order signed on July 20, 2023, which indicated to inject 10 units (u) of Novolog (insulin aspart) FlexPen Solution pen-injector 100u/milliliter (ml) subcutaneously (SQ) three times a day for DM2.</p> <p>R2's electronic record in PointClickCare (PCC) (charting software) included a Novolog insulin order dated March 30, 2023, which indicated to inject 10u of Novolog FlexPen Solution pen-injector 100u/ml (insulin aspart) SQ three times a day for DM2.</p> <p>On July 31, 2023, at 11:20 a.m., the surveyor observed unlicensed personnel (ULP)-B check R2's blood glucose (BG) levels and administer R2's Novolog insulin. ULP-B showed the surveyor their computer which prompted the Novolog insulin order as, "inject 4 units additional for blood glucose at mealtimes if &gt;350 ++update provider &lt;70 or &gt;450. Hold for blood glucose &lt;100++and inject 10 units sub-q three times daily with meals." R2's BG result was 320, ULP-B administered 10u of Novolog insulin per the order.</p> <p>Due to delays from the licensee in providing access to resident records, R2's medication orders could not be reviewed until August 1, 2023.</p> | 01820                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01820                                                               | <p>Continued From page 57</p> <p>On August 1, 2023, at 10:25 a.m., the surveyor inquired about R2's Novolog insulin orders with licensed practical nurse (LPN)-A and clinical nurse supervisor (CNS)-C who then searched through R2's physical and electronic records with the surveyor; neither were able to locate Novolog insulin orders to include, "inject 4 units additional for blood glucose at mealtimes if &gt;350."</p> <p>On August 1, 2023, at 11:22 a.m., CNS-C stated they had continued to search R2's record for orders which included the extra 4u for BG &gt;350 without success. CNS-C stated they called the nurse practitioner (NP)-L to clarify the Novolog insulin orders, but NP-L wanted to review R2's chart before clarifying the order due to the confusion. NP-L gave a verbal order to hold the insulin until they contacted them back in 15 minutes.</p> <p>On August 1, 2023, at 12:30 p.m., CNS-C stated they received a verbal order for R2's Novolog insulin to include the extra 4u of insulin for BG &gt;350, they stated NP-L would be in to sign it and would provide the surveyor a copy. CNS-C stated they did not know why PCC would prompt a different order instruction for the ULPs versus what was in the orders which were also in PCC. CNS-C stated they would need to seek further guidance to investigate what was going on with PCC.</p> <p>On August 2, 2023, at 10:30 a.m., LPN-A provided R2's updated Novolog insulin order signed by NP-L on August 1, 2023, which indicated, "Continue Novolog 10u TID (three times per day) with meals. Ok for additional Novolog 4u TID PRN (as needed) with meals if BG &gt;350."</p> | 01820                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                         |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01820                                                               | Continued From page 58<br><br>The licensee's Medication Management policy dated August 19, 2021, indicated, " There must be a current written or electronically recorded prescription for all prescribed (including OTC) medications that the community is managing for the resident."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 01820                                                                                                   |                                                                                                                          |  |                                                        |
| 01880<br>SS=F                                                       | <b>144G.71 Subd. 19 Storage of medications</b><br><br>An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to monitor the temperature of their medication storage refrigerator to ensure required medications were stored according to manufacturer directions for eight of eight residents with refrigerated medications (R2, R3, R5, R10, R12, R13, R14, R15).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all | 01880                                                                                                   |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                         |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01880                                                               | <p>Continued From page 59</p> <p>of the residents).</p> <p>The findings include:</p> <p>On July 31, 2023, at 9:55 a.m., the surveyor observed the facility's medication refrigerator with licensed practical nurse (LPN)-A. The medication refrigerator had a padlock and was also behind a locked door in the nursing office. It had a classic thermometer which read 42 degrees Fahrenheit (F). There was one Daily Medication Refrigerator Temperature Log dated July 2023, which only had two temperatures logged on July 26 and 27, 2023, both at 42 degrees F. The medication refrigerator contained the following medications:</p> <ul style="list-style-type: none"><li>-R2 insulin aspart flexpen 100 units (u)/ml prefilled syringe, expiration April 30, 2025, six flexpens, Novo Nordisk manufacturer;</li><li>-R2 Lantus SoloStar injection pen 100 u/ml insulin, expiration August 31, 2025, three pens;</li><li>-R3 latanoprost 0.005% eye drops bottle 125 micrograms (mcg)/2.5 milliliters (ml) solution, expiration date October 2025, one bottle, Bausch-Lomb manufacturer;</li><li>-R5 insulin aspart flexpen 100 units (u)/ml prefilled syringe, expiration April 30, 2025, seven flexpens, Novo Nordisk manufacturer;</li><li>-R5 Lantus SoloStar injection pen 100 u/ml insulin, six pens;</li><li>-R10 gabapentin 50 milligrams (mg)/ml oral suspension mixed by Omnicare Minnesota pharmacy, expiration July 5, 2023, blue sticker label indicated, "shake well and keep in refrigerator;</li><li>-R12 latanoprost 0.005% eye drops bottle 125mcg/2.5ml solution, one bottle, Greenstone Brand manufacturer;</li><li>-R13 latanoprost 0.005% eye drops bottle 125mcg/2.5ml solution, one bottle, Somerset manufacturer;</li></ul> | 01880                                                                                                   |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                         |                                                                                                                          |                                                        |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 01880                                                               | <p>Continued From page 60</p> <p>-R14 calcitonin - salmon 200u/1 dose spray 3.7ml, one bottle, expiration date February 2025, Apotex manufacturer; and</p> <p>-R15 Basaglar KwikPen 100u/ml insulin, expiration February 8, 2025, one pen.</p> <p>On July 31, 2023, at 9:55 a.m., LPN-A stated she was unsure who primarily monitored the medication refrigerator temperature and thought it was supposed to be checked on a daily basis. LPN-A stated they had checked it one time in the past but thought maybe the clinical nurse supervisor (CNS)-C checked it more regularly. LPN-A was unsure if they had any temperature logs prior to July 2023.</p> <p>On August 2, 2023, at 11:54 a.m., CNS-C stated the nursing staff were responsible for monitoring the medication refrigerator temperature on a daily basis. CNS-C stated they personally assigned the task to a nurse every morning but there wasn't a formal task sheet for nurses to go off of, on weekends it could be assigned to unlicensed personnel (ULP), but stated she wasn't normally at the facility on weekends. CNS-C stated they did not have any Daily Medication Refrigerator Temperature Log from previous months this year. CNS-C stated they needed to develop a better monitoring system.</p> <p>Manufacturer Novo Nordisk directions for insulin aspart flexpen copywrite 2023, indicated store refrigerated at 2°C to 8°C (36°F to 46°F) until first use. After first use store at room temperature (up to 30°C [86°F]) and discard after 28 days.</p> <p>Manufacturer directions for Lantus SoloStar injection pen revised December 2020, indicated unopened pens could be stored refrigerated 36°F to 42°F until the expiration date.</p> | 01880                                                                                                   |                                                                                                                          |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                         |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01880                                                               | <p>Continued From page 61</p> <p>Manufacturer Bausch-Lomb directions for latanoprost 0.005% eye drops copywrite 2020, indicated protect from light. Store unopened bottle(s) under refrigeration at 2° to 8°C (36° to 46°F). During shipment to the patient, the bottle may be maintained at temperatures up to 40°C (104°F) for a period not exceeding 8 days. Once a bottle is opened for use, it may be stored at room temperature up to 25°C (77°F) for 6 weeks.</p> <p>Manufacturer Greenstone Brand directions for latanoprost 0.005% eye drops copywrite 2020, indicated protect from light. Store unopened bottle(s) under refrigeration at 2°C to 8°C (36°F to 46°F). During shipment to the patient, the bottle may be maintained at temperatures up to 40°C (104°F) for a period not exceeding 8 days. Once a bottle is opened for use, it may be stored at room temperature up to 25°C (77°F) for 6 weeks.</p> <p>Manufacturer Somerset directions for latanoprost 0.005% eye drops revised on November 2019, indicated, store unopened bottle(s) under refrigeration at 2° to 8°C (36° to 46°F). During shipment to the patient, the bottle may be maintained at temperatures up to 40°C (104°F) for a period not exceeding 8 days. Once a bottle is opened for use, it may be stored at room temperature up to 25°C (77°F) for 6 weeks.</p> <p>Manufacturer Apotex directions for Calcitonin Salmon (synthetic origin) Nasal Spray revised November 2017, indicated to store unopened bottles of Calcitonin Salmon (synthetic origin) Nasal Spray in the refrigerator between 36°F to 46°F. Do not freeze.</p> <p>Manufacturer directions for Basaglar KwikPen insulin revised November 2022, indicated to store</p> | 01880                                                                                                   |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                         |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b>                                  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01880                                                               | Continued From page 62<br><br>unused pens in the refrigerator at 36°F to 46°F.<br>Do not freeze Basaglar and do not use if it has<br>been frozen.<br><br>The licensee provided an Infection Prevention<br>and Control Program for Assisted Living<br>Communities v3.0 dated May 2023, which<br>indicated, "Medications should be stored in areas<br>with adequate lighting, ventilation, temperature,<br>sanitation, humidity, space, equipment, and<br>security conditions. Medications requiring specific<br>temperature conditions should be stored<br>accordingly. If no storage requirements are<br>indicated, the medication can be stored at room<br>temperature. Medications requiring refrigeration<br>must be kept in a refrigerator designated for<br>medications only."<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7)<br>days | 01880                                                                                                   |                                                                                                                          |  |                                                     |
| 01890<br>SS=D                                                       | 144G.71 Subd. 20 Prescription drugs<br><br>A prescription drug, prior to being set up for<br>immediate or later administration, must be kept in<br>the original container in which it was dispensed<br>by the pharmacy bearing the original prescription<br>label with legible information including the<br>expiration or beyond-use date of a time-dated<br>drug.<br><br>This MN Requirement is not met as evidenced<br>by:<br>Based on observation, interview, and record<br>review, the licensee failed to ensure expired<br>medications were disposed of for one of eight<br>residents (R1).                                                                                                                                                                                                                                                                                 | 01890                                                                                                   |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01890                                                               | <p>Continued From page 63</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R10's Service Plan dated May 10, 2023, indicated R10 received medication management services.</p> <p>R10's record included an order for gabapentin dated April 6, 2023, which indicated to take 250 milligrams (mg), or 5 milliliters (ml), of gabapentin 50 milligrams (mg)/ml oral solution every 24 hours as needed (PRN) for pain.</p> <p>On July 31, 2023, at 9:55 a.m., the surveyor observed the facility's medication storage refrigerator with licensed practical nurse (LPN)-A and found an orange pharmacy bottle of gabapentin 50mg/ml oral suspension, take 5mls (250mg) by mouth daily PRN with a handwritten expiration date, "exp 7-5-23" for R10. LPN-A stated they were pretty sure R10 was still prescribed the medication.</p> <p>On July 31, 2023, at 10:15 a.m., LPN-A looked up R10 in PointClickCare (PCC (charting software)) and confirmed R10 was currently taking the medication on a PRN basis. LPN-A stated it was the nursing staff who were supposed to review the medication refrigerator, primarily the clinical nurse supervisor (CNS), to look for expired medication. They were unsure how often they were supposed to review the refrigerator.</p> | 01890                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01890                                                               | <p>Continued From page 64</p> <p>On August 2, 2023, at 11:54 a.m., CNS-C stated they disposed of the expired gabapentin for R10. CNS-C stated the nursing staff were responsible for monitoring the medication refrigerator for expired medications on a daily basis. CNS-C stated they personally assigned the task to a nurse every morning but there wasn't a formal task sheet for nurses to go off of, on weekends it could be assigned to unlicensed personnel (ULP), but stated they weren't normally at the facility on weekends. CNS-C stated they needed to develop a better monitoring system.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>                                                                                                                               | 01890                                                                  |                                                                                                                          |  |                                                     |
| 01940<br>SS=D                                                       | <p><b>144G.72 Subd. 3 Individualized treatment or therapy managemen</b></p> <p>For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following:</p> <p>(1) a statement of the type of services that will be provided;</p> <p>(2) documentation of specific resident instructions relating to the treatments or therapy administration;</p> <p>(3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel;</p> | 01940                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01940                                                               | <p>Continued From page 65</p> <p>(4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and</p> <p>(5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of two residents (R5).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R5 admitted to the licensee on April 17, 2023, and began receiving assisted living services.</p> <p>R5's diagnosis included type 2 diabetes mellitus with diabetic chronic kidney disease.</p> | 01940                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01940                                                               | <p>Continued From page 66</p> <p>R5's unsigned service plan, indicated R5 received assistance with medication management including administration of insulin, meals, transportation, bathing, and laundry.</p> <p>R5's provider order dated May 20, 2023, included obtain blood glucose four times daily for diabetes.</p> <p>On August 2, 2023, at 7:47 a.m., the surveyor observed unlicensed personnel (ULP-B) perform blood glucose monitoring on R5.</p> <p>R5's medication administration record (MAR) dated August 1 through August 31, 2023, included obtain blood glucose for times daily for diabetes and record for diabetes.</p> <p>R5's MN 3.0 SEHA - V10 ongoing assessment dated May 17, 2023, included signs and symptoms of high and low blood sugars and indicated R5 received blood glucose and insulin before all meals.</p> <p>R5's unsigned service plan, provider order dated May 20, 2023, MAR dated August 1 through August 31, 2023, and MN 3.0 SEHA - V10 dated May 17, 2023, included parts of the individualized treatment management plan. The individualized treatment management plan lacked procedures for staff to notify an RN when problems arose with blood glucose monitoring.</p> <p>On August 2, 2023, at 7:54 a.m., ULP-B stated R5 "always" had high blood glucose readings however, if R5's blood glucose reading was low they would contact a nurse and give them orange juice to raise the blood glucose level. The surveyor inquired if there was information on when to call the nurse for a high blood glucose rating. ULP-B stated no, only when the blood</p> | 01940                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                         |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01940                                                               | Continued From page 67<br><br>glucose was low, they contacted the nurse and that was written with the insulin order.<br><br>On August 2, 2023, at 12:27 p.m., clinical nurse supervisor (CNS)-C stated ULP should alert a nurse when a resident's blood glucose is above 250 milligrams /deciliter (mg/dl) so they can alert the provider. The surveyor inquired if they had these instructions written anywhere in R5's medical record. CNS-C stated they did not.<br><br>The licensee's Delegation of Nursing Tasks, Treatments or Therapy Tasks policy dated August 19, 2021, indicated the resident care coordinator (RCD) or registered nurse (RN) may delegate nursing tasks consistent with the Minnesota (MN) Nurse Practice Act, the MN Assisted Living Laws, and the accepted standard of nursing practice.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01940                                                                                                   |                                                                                                                          |  |                                                        |
| 01970<br>SS=D                                                       | 144G.72 Subd. 6 Treatment and therapy orders<br><br>There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record                                                                                                                                                                                                                                                                                                                              | 01970                                                                                                   |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01970                                                               | <p>Continued From page 68</p> <p>review, the licensee failed ensure up-to-date written or electronically treatment orders were maintained for one of four residents (R2).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R2 was admitted to the licensee on September 27, 2021, with a diagnosis of diabetes type II.</p> <p>R2's Service Plan signed on September 27, 2021, indicated R2 received services for medication and diabetic management.</p> <p>R2's medication administration record (MAR) for July 2023, indicated BG monitoring was being completed three times per day along with Novolog FlexPen insulin administration at 7:30 a.m., 11:30 a.m., and 4:30 p.m.</p> <p>R2's medical record lacked BG monitoring orders to include frequency of BG checks.</p> <p>On July 31, 2023, at 11:20 a.m., the surveyor observed unlicensed personnel (ULP)-B check R2's blood glucose (BG) and administer insulin.</p> <p>On August 2, 2023, at 11:54 a.m., clinical nurse supervisor (CNS)-C stated treatment orders, which included BG monitoring orders, were required and was not sure why R2's record didn't</p> | 01970                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                         |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01970                                                               | Continued From page 69<br><br>have them. CNS-C stated they would review R2's<br>record and obtain orders.<br><br>The licensee's Delegation of Nursing Tasks,<br>Treatments or Therapy Tasks policy dated August<br>19, 2021, did not address treatment orders.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7)<br>days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 01970                                                                                                   |                                                                                                                          |  |                                                        |
| 02040<br>SS=F                                                       | <b>144G.81</b> Subdivision 1 Fire protection and<br>physical environment<br><br>An assisted living facility with dementia care that<br>has a secured dementia care unit must meet the<br>requirements of section 144G.45 and the<br>following additional requirements:<br>(1) a hazard vulnerability assessment or safety<br>risk must be performed on and around the<br>property. The hazards indicated on the<br>assessment must be assessed and mitigated to<br>protect the residents from harm; and<br>(2) the facility shall be protected throughout by an<br>approved supervised automatic sprinkler system<br>by August 1, 2029.<br><br>This MN Requirement is not met as evidenced<br>by:<br>Based on record review and interview, the<br>licensee failed to provide a hazard vulnerability<br>assessment or safety risk assessment of the<br>physical environment on and around the property<br>for the facility. This deficient practice had the<br>ability to affect all staff, residents, and visitors.<br><br>This practice resulted in a level two violation (a<br>violation that did not harm a resident's health or | 02040                                                                                                   |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                 |                                                                                                                          |  |                                              |
|--------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>23982                                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>08/02/2023 |
| NAME OF PROVIDER OR SUPPLIER<br><br>SUNRISE OF GOLDEN VALLEY |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>4950 OLSON MEMORIAL HIGHWAY<br>GOLDEN VALLEY, MN 55422 |                                                                                                                          |  |                                              |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                     |
| 02040                                                        | <p>Continued From page 70</p> <p>safety but had the potential to have harmed a resident's health or safety but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>Findings include:</p> <p>A record review of the available documentation and interview was conducted on August 01, 2023, at approximately 12:00 p.m. with the Maintenance Coordinator (MC)-F on the hazard vulnerability assessment for the physical environment of the facility. The record review indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property.</p> <p>During the interview, MC-F stated that he did not think the licensee had performed a hazard vulnerability assessment for the physical environment on or around the property the documentation and stated that a follow up email with the record would be provided.</p> <p>Review of the follow up record received from MC-F on August 2, 2023, indicated that licensee had conducted a hazard vulnerability assessment for the emergency disaster and a geographic hazard vulnerability Assessment for the facility but had not conducted a hazard vulnerability assessment of the physical environment with mitigation factors on and around the property.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p> | 02040                                                                                           |                                                                                                                          |  |                                              |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 02090                                                               | Continued From page 71                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 02090                                                                  |                                                                                                                          |  |                                                     |
| 02090<br>SS=D                                                       | <p><b>144G.82 Subdivision 1 General</b></p> <p>The licensee of an assisted living facility with dementia care is responsible for the care and housing of the persons with dementia and the provision of person-centered care that promotes each resident's dignity, independence, and comfort. This includes the supervision, training, and overall conduct of the staff.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to maintain dignified incontinence management for one of four residents (R1).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R1 was admitted to the licensee on March 30, 2023. R1's Service Plan, unsigned and not dated, indicated R1 received services for bladder incontinence two to four times per shift.</p> <p>On July 31, 2023, at 1:12 p.m., the surveyor observed R1 sitting in their wheelchair (w/c) in the commons area with a disposable chux pad (pad to absorb urine) between her buttocks and the w/c. The chux pad hung out and over the end of the w/c visible to anyone within eyesight of R1.</p> | 02090                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 02090                                                               | <p>Continued From page 72</p> <p>On July 31, 2023, at 1:15 p.m., unlicensed personnel (ULP)-G and ULP-I both stated it was normal for them to have a chux pad under R1 while they were in their w/c. ULP-G stated sometimes R1 soaked through when R1 urinated in their brief (adult diaper) so it kept an accident from becoming a mess. ULP-G stated it wasn't something they were instructed to do by the nursing staff.</p> <p>On August 2, 2023, at 11:54 a.m., clinical nurse supervisor (CNS)-C stated a chux pad should never be used in the manner described as it was a dignity issue, and ULPs were never told to use a chux pad in a w/c. CNS-C stated ULPs should be offering a chance for the resident to use the bathroom and performing brief checks as scheduled.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Two (2) days</p> | 02090                                                                  |                                                                                                                          |  |                                                     |
| 02110<br>SS=C                                                       | <p>144G.82 Subd. 3 Policies</p> <p>(a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the:</p> <p>(1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented;</p> <p>(2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are</p>                                                                                                                                                                                                                                                             | 02110                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 02110                                                               | <p>Continued From page 73</p> <p>person-centered and evidence-informed;<br/>(3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes;<br/>(4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications;<br/>(5) staff training specific to dementia care;<br/>(6) description of life enrichment programs and how activities are implemented;<br/>(7) description of family support programs and efforts to keep the family engaged;<br/>(8) limiting the use of public address and intercom systems for emergencies and evacuation drills only;<br/>(9) transportation coordination and assistance to and from outside medical appointments; and<br/>(10) safekeeping of residents' possessions.<br/>(b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to ensure policies and procedures for assisted living with dementia care (ALFDC) were provided to residents or the resident's legal and / or designated representative at the time of move-in or at the time they began receiving assisted living services for four of four residents (R1, R2, R3, R5).</p> <p>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive</p> | 02110                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                         |                                                                                                                          |                                                        |
|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 02110                                                               | <p>Continued From page 74</p> <p>or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>R1 admitted to licensee March 30, 2023, and started receiving assisted living services.</p> <p>R2 admitted to licensee September 27, 2021, and started receiving assisted living services.</p> <p>R3 admitted to licensee May 16, 2023, and started receiving assisted living services.</p> <p>R5 admitted to licensee April 17, 2023, and started receiving assisted living services.</p> <p>R1, R2, R3, and R5's resident records lacked evidence the licensee provided a resident or resident representative policies and procedures that addressed 144G.82 Subd. 3., at the time of move-in to the facility or upon conversion to assisted living licensure.</p> <p>On August 2, 2023, at 1:50 p.m., the surveyor inquired if the licensee provided policies and procedures for ALFDC to residents or resident's legal and / or designated representative at the time of move-in licensed assisted living director (LALD)-D stated, "I don't think so. To be honest, I don't think we do that."</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p> | 02110                                                                                                   |                                                                                                                          |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 02310                                                               | Continued From page 75                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 02310                                                                  |                                                                                                                          |  |                                                     |
| 02310<br>SS=I                                                       | <p><b>144G.91 Subd. 4 (a) Appropriate care and services</b></p> <p>(a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R3) with an assistive device (consumer bed rail).</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>R3 admitted to the licensee on May 16, 2023, and began receiving assisted living services.</p> <p>R3's diagnoses included syncope (fainting) with collapse, Alzheimer's disease with late onset, and hypertension.</p> <p>R3's service plan signed May 19, 2023, indicated R3 received assistance with meals, medication management, activities, behavior management,</p> | 02310                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                         |                                                                                                                          |                                                        |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 02310                                                               | <p>Continued From page 76</p> <p>oral cares, transferring assist of one, grooming assist of one, dressing assist of one, toileting assist of one, laundry, and bathing.</p> <p>On August 1, 2023, at 10:22 a.m., the surveyor observed R3's bed had Halo Safety Ring bed rails (consumer bed rail) at the top of the bed on each side of the bed. The bed rails were firmly attached to the bed.</p> <p>R3's record lacked:</p> <ul style="list-style-type: none"> <li>- Purpose and intention of the bed rail;</li> <li>- Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail;</li> <li>- The resident's bed rail use/need assessment;</li> <li>- Risk vs. benefits discussion (individualized to each resident's risks);</li> <li>- The resident's preferences;</li> <li>- Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and</li> <li>- Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements.</li> </ul> <p>On August 2, 2023, at 10:28 a.m., maintenance coordinator (MC)-F stated they would normally become involved with bed rails after residents were assessed by therapy to see if bed rails were appropriate and after a provider order was obtained. MC-F would then apply the bed rails per the manufactures guidelines or FDA requirements and notify a nurse to assess the device after the instillation. In addition, MC-F stated the nurse and maintenance were supposed to complete monthly inspection rounds on the devices.</p> <p>On July 31, 2023, at 11:04 a.m., surveyor observed R11's hospital bed which had bed rails.</p> | 02310                                                                                                   |                                                                                                                          |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                         |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 02310                                                               | <p>Continued From page 77</p> <p>On August 2, 2023, at 11:53 a.m., clinical nurse supervisor (CNS)-C stated residents were assessed by therapy for use of bed rails and once therapy approved a bed rail nursing would obtain a provider order than have maintenance install a bed rail. CNS-C stated after the bed rail was applied the CNS and MC would complete monthly rounds on the device. The surveyor asked if they had completed any monthly rounds. CNS-C stated they had only been in the position a month and a half, therefore, they had not yet completed any rounds. The surveyor asked if they completed a nursing assessment for the use of bed rails. CNS-C stated the licensee's process was to obtain a provider's order after therapy determined a need for use. CNS-C stated they had not conducted any bed rail assessments.</p> <p>On August 2, 2023, at 1:38 p.m., during an interview with CNS-C and LALD-D, LALD-D provided a log form of MC-F's monthly rounds titled, Healthcare Bed Test &amp; Inspection Log, dated June 2022. The log indicated five residents bed rails were measured for zones of entrapment. The document did not differentiate between consumer bed rails and hospital bed rails. The document included FDA zones of entrapment for hospital bed rails and included a "P" or an "F" for pass or fail. The surveyor inquired how many current residents had bed rails. CNS-C stated they thought there were 13 residents with bed rails. CNS-C provided the surveyor with a list which included 15 identified rooms with bed rails. The list included residents R8 and R10. CNS-C stated they were unable to locate any bed rail assessments for any of their residents, and they had not completed any bed rail assessment since becoming the CNS in June 2023. In addition, CNS-C provided the surveyor</p> | 02310                                                                                                   |                                                                                                                          |  |                                                        |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                         |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b>                                  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 02310                                                               | <p>Continued From page 78</p> <p>with a blank document titled Acknowledgement and Consent for the Use of a Transfer Assistive Device and stated they found the form and asked surveyors if it was something they should be using. LALD-D and CNS-C both stated they did not understand the procedure and asked for clarification on what they were supposed to be doing for bed rails which included how often assessments should be done, which bed rails need measurements, manufacturer instructions, if they should use their risk versus benefits form for anyone with a bed rail, and how often MC-F should have been checking for safe installation. CNS-C stated staff should have been alerting nursing if they discovered a new bed rail in someone's room but wasn't sure if staff knew they were supposed to be doing so.</p> <p>On August 2, 2023, at 1:52 p.m., LALD-D stated nursing had not completed any bed rail assessments for consumer or hospital bed rails since he was hired in April 2023. The surveyor inquired if they completed risk and benefits with residents' families related to bed rails. LALD-D stated they do talk to families when a bed rail is recommended by therapy, however, the licensee maintained no documentation of this, and they were unsure if the risk and benefits were discussed with family.</p> <p>On August 2, 2023, at approximately 2:15 p.m., surveyor observed one halo safety ring consumer bed rail's on R6 and R7's beds, and two halo safety rings on R9's bed.</p> <p>On August 2, 2023, at 2:14 p.m., R8 stated they used to have a bed rail, but the facility took it away from them some time ago. R8 stated they could not remember who removed it, but they were told it was a safety issue and they could not</p> | 02310                                                                                                   |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 02310                                                               | <p>Continued From page 79</p> <p>have the bed rail.</p> <p>On August 2, 2023, at 2:27 p.m., the surveyor observed R10 in their hospital bed. R10 stated they have never had a bed rail.</p> <p>The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe."</p> <p>The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle.</p> <p>The Minnesota Department of Health (MDH) website, Assisted Living Resources &amp; Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the</p> | 02310                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        |                                                                                                                          |  |                                                     |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23982</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b>                  |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 02310                                                               | <p>Continued From page 80</p> <p>intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to:</p> <ul style="list-style-type: none"><li>- Purpose and intention of the bed rail;</li><li>- Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail;</li><li>- The resident's bed rail use/need assessment;</li><li>- Risk vs. benefits discussion (individualized to each resident's risks);</li><li>- The resident's preferences;</li><li>- Installation and use according to manufacturer's guidelines;</li><li>- Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and</li><li>- Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements".</li></ul> <p>Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations.</p> <p>The licensee's Bed Safety Program dated February 2019 indicated the nurse would determine the need and type of assistive device used by a resident and a resident who used an assistive device would be reevaluated by the nurse to determine if the continued use of the device is necessary and appropriate. In addition,</p> | 02310                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                         |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>23982</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/02/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF GOLDEN VALLEY</b> |                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4950 OLSON MEMORIAL HIGHWAY<br/>GOLDEN VALLEY, MN 55422</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 02310                                                               | <p>Continued From page 81</p> <p>the resident care team had a responsibility to discuss the risks involved, as well as the benefits of any clinical and/or environmental interventions that may be safer in meeting the resident's evaluated needs, individual circumstances, and environment.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: IMMEDIATE</p> | 02310                                                                                                   |                                                                                                                          |  |                                                        |



Type: Full  
Date: 08/01/23  
Time: 13:52:16  
Report: 1023231146

## Food and Beverage Establishment Inspection Report

Page 1

**Location:**

Sunrise Of Golden Valley  
4950 Olson Memorial Highway  
Golden Valley, MN55422  
Hennepin County, 27

**Establishment Info:**

ID #: 0039352  
Risk:  
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 7635224000  
ID #:

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

The following orders were issued during this inspection.

### 4-300 Equipment Numbers and Capacities

#### 4-302.13B **\*\* Priority 2 \*\***

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

HIGH TEMP DISH MACHINE IN USE BUT OPERATOR STATED NO METHOD OF VERIFYING INTERNAL TEMP AVAILABLE. ACQUIRE AND USE THIS DEVICE TO ENSURE PATHOGEN DESTRUCTION.

*Comply By: 08/01/23*

### 4-600 Cleaning Equipment and Utensils

#### 4-601.11A **\*\* Priority 2 \*\***

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch. TABLE MOUNTED CAN OPENER STORED WITH DRIED FOOD DEBRIS ON BLADE. CLEAN UTENSILS AFTER USE AND STORE IN CLEAN CONDITION.

*Comply By: 08/01/23*

### 2-100 Supervision

#### 2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment. NO CFPM AT THIS LOCATION. MAIL IN APPLICATION TO MDH TO RECEIVE CERTIFICATE.

*Comply By: 08/01/23*



Type: Full  
Date: 08/01/23  
Time: 13:52:16  
Report: 1023231146  
Sunrise Of Golden Valley

# Food and Beverage Establishment Inspection Report

Page 2

---

## 4-500 Equipment Maintenance and Operation

### 4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

MEMORY CARE MICROWAVE INTERIOR DETERIORATED SUCH THAT PLASTIC IS FORMING BUBBLES AND FALLING OFF. REPAIR/REPLACE MICROWAVE.

*Comply By: 08/01/23*

## 6-300 Physical Facility Numbers and Capacities

### 6-301.14A

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

ALL HAND SINKS MUST HAVE REMINDER SIGNS.

*Comply By: 08/01/23*

---

## Surface and Equipment Sanitizers

S&S: = 700PPM at Degrees Fahrenheit

Location: 3 COMP DISPENSER

Violation Issued: No

---

Hot Water: = at 162 Degrees Fahrenheit

Location: DISH MACHINE

Violation Issued: No

---

## Food and Equipment Temperatures

Process/Item: Cold Hold/EGG SALAD

Temperature: 41 Degrees Fahrenheit - Location: PREP COOLER

Violation Issued: No

---

Process/Item: Cold Hold/HAM

Temperature: 39 Degrees Fahrenheit - Location: WALK IN COOLER

Violation Issued: No

---

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. INSPECTION CONDUCTED IN PRESENCE OF THE PERSON IN CHARGE.

THIS FACILITY HAS COMMERCIAL EQUIPMENT IN A MAIN KITCHEN AREA, BISTRO AREA, AND MEMORY CARE AREA. FOOD SERVICE IS PROVIDED BY CARE FACILITY STAFF.

THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:

- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- FOOD COOLING METHODS



Type: Full  
Date: 08/01/23  
Time: 13:52:16  
Report: 1023231146  
Sunrise Of Golden Valley

# Food and Beverage Establishment Inspection Report

Page 3

- FOOD REHEATING METHODS
- VOMIT CLEAN UP PROCEDURE
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- PASTEURIZED SHELL EGGS

TO GET A CFPM YOU MUST TAKE EIGHT HOUR MANAGER CLASS, PASS TEST, AND MAIL APPLICATION IN TO MDH. YOU CAN SIGN UP FOR FOOD MANAGER COURSES HERE:  
<https://fmctraining.web.health.state.mn.us/search/index.cfm>

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1023231146 of 08/01/23.

Certified Food Protection Manager: MICHAEL LEAHY

Certification Number: SERVESAF Expires:  / /

**Inspection report reviewed with person in charge and emailed.**

Signed: \_\_\_\_\_

MICHAEL LEAHY  
PERSON IN CHARGE

Signed: Gregory T Nelson

Gregory T. Nelson  
Public Health Sanitarian  
Freeman Building  
651-201-4259  
[greg.nelson@state.mn.us](mailto:greg.nelson@state.mn.us)