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

Electronically Delivered

October 3, 2022

Administrator
Sunrise View Assisted Living
603 Louisiana Avenue
Adrian, MN 56110

RE: Project Number(s) SL32183015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on August 31, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

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

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

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

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

**The total amount you are assessed is $500.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

**DOCUMENTATION OF ACTION TO COMPLY**

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

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

**CORRECTION ORDER RECONSIDERATION PROCESS**

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

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general 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

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

**REQUESTING A HEARING**
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date.  Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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

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

Sincerely,

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jess.gallmeier@state.mn.us
Phone: 651-247-0268 Fax: 651-215-9697

HHH

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 32183 | A. BUILDING: ______ B. WING ______ | 08/31/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SUNRISE VIEW ASSISTED LIVING** | **603 LOUISIANA AVENUE ADRIAN, MN 56110** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 0 000 | Initial Comments<br><br>Initial comments<br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.<br><br>INITIAL COMMENTS:<br>SL32183015<br><br>On August 30, 2022 through August 31, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 9 residents receiving services under the provider's Assisted Living Dementia Care license. | 0 000 | Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. | |
| 0 480<br>SS=F | 144G.41 Subd 1 (13) (i) (B) Minimum requirements<br><br>(13) offer to provide or make available at least the following services to residents:<br><br>(i) at least three nutritious meals daily with snacks | 0 480 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 32183 | A. BUILDING: ______ B. WING ______ | 08/31/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNRISE VIEW ASSISTED LIVING | 603 LOUISIANA AVENUE ADRIAN, MN 56110 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 0 480 | Continued From page 1<br><br>available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply:<br><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>Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all nine (9) residents in the Assisted Living facility.<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 the residents).<br><br>The findings include:<br><br>Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated August 30, 2022, for the specific Minnesota Food Code deficiencies.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 480 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 32183 | A. BUILDING: ____ B. WING ____ | 08/31/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNRISE VIEW ASSISTED LIVING | 603 LOUISIANA AVENUE ADRIAN, MN 56110 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 0 485 | Continued From page 2 | 0 485 | | |
| 0 485 SS=F | 144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements<br><br>(13) offer to provide or make available at least the following services to residents:<br><br>(i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply:<br><br>(A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes;<br><br>(C) the facility cannot require a resident to include and pay for meals in their contract;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure a menu was prepared a week in advance and provided to the residents. This had the potential to affect all nine (9) residents who received services.<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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when | 0 485 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 32183 | A. BUILDING: ______ B. WING ______ | 08/31/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SUNRISE VIEW ASSISTED LIVING** | **603 LOUISIANA AVENUE ADRIAN, MN 56110** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 0 485 | Continued From page 3<br>problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On August 30, 2022, at approximately 9:35 a.m., the surveyor observed the menu posted on the communication board was not at least one week in advance. The menu posted was the menu for August 30, 2022.<br><br>On August 30, 2022, at approximately 1:55 p.m., licensed assisted living director (LALD)-D acknowledged the week in advance menu was not posted and stated that this should have been posted in the same location as the daily menu.<br><br>The licensee's Food Service policy dated March 2021, did not indicate when or how the licensee's menu would be distributed to residents for review.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 485 | | |
| 0 490<br>SS=F | 144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements<br><br>(ii) weekly housekeeping;<br>(iii) weekly laundry service;<br>(iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; | 0 490 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 32183 | A. BUILDING: ___ B. WING ___ | 08/31/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SUNRISE VIEW ASSISTED LIVING** | **603 LOUISIANA AVENUE ADRIAN, MN 56110** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 0 490 | Continued From page 4 | 0 490 | | |

(v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance;
(vi) provide culturally sensitive programs; and
(vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and

This MN Requirement is not met as evidenced by:
Based on observation and interview, the licensee failed to provide a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs for two of two residents (R1, R3) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients).

The findings include:

During a facility wide tour on August 30, 2022, at approximately 9:30 a.m., the surveyor noted a monthly activity calendar posted on a common

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 32183 | A. BUILDING: ______ B. WING ______ | 08/31/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SUNRISE VIEW ASSISTED LIVING** | **603 LOUISIANA AVENUE ADRIAN, MN 56110** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 0 490 | Continued From page 5<br><br>wall which indicated daily activities for both the morning and the afternoon of each day. The daily activity for the morning schedule on August 30, 2022, indicated upper arm exercises.<br><br>During observations on August 30, 2022, from approximately 9:30 a.m. to 1:15 p.m., the surveyor did not observe any activities offered for the licensee's residents.<br><br>During interview on August 30, 2022, at approximately 11:40 a.m., unlicensed personnel (ULP)-C stated the ULPs were responsible to provide daily activities for the licensee's residents. ULP-C stated she was not aware there was an activity calendar posted. ULP-C also stated the ULPs have not been providing activities to residents on a daily basis.<br><br>During interview on August 30, 2022, at approximately 11:55 a.m., R1 stated that she was not aware of any calendar indicating what activities were available for residents. R1 also stated that staff did not provide any activities. R1 stated she believed the residents did play bingo at one time but cannot remember any other activities. R1 stated all they do is eat and sleep.<br><br>On August 30, 2022, at approximately 2:00 p.m., licensed assisted living director (LALD)-D stated the licensee was to provide daily activities to all residents and that the licensee did have a calendar listing all the activities available to residents. LALD-D acknowledged that the staff were not providing any activities and believes that this is something that licensee needs to work on.<br><br>The licensee's Activity Programming policy, dated March 2021, indicated on a regular basis, the licensee would provide a wide range of activities | 0 490 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 32183 | A. BUILDING: ___ B. WING ___ | 08/31/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNRISE VIEW ASSISTED LIVING | 603 LOUISIANA AVENUE ADRIAN, MN 56110 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 0 490 | Continued From page 6<br>and social recreation for its residents.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 490 | | |
| 0 510 SS=F | 144G.41 Subd. 3 Infection control program<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 assisted living facilities.<br>(c) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to establish and maintain infection control policies and procedures that complied with accepted health care, medical, and nursing standards for infection control related to the COVID-19 pandemic when the licensee failed to ensure visitors, employees, and residents were screened for COVID-19 with temperature checks and screening questions and failed to develop policies and procedures to guide decision making related to COVID-19 pandemic. The licensee also failed to ensure appropriate personal protective equipment was worn in the facility during resident and staff interactions. | 0 510 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 32183 | A. BUILDING: ______ B. WING ______ | 08/31/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNRISE VIEW ASSISTED LIVING | 603 LOUISIANA AVENUE ADRIAN, MN 56110 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 0 510 | Continued From page 7 | 0 510 | | |

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 all four residents).

The findings include:

On August 30, 2022, at 9:10 a.m., the surveyor was greeted at the front door by unlicensed personnel (ULP)-B. ULP-B was wearing a face mask covering the nose and mouth. ULP-B wrote down the surveyor's name on a sheet of paper and proceeded to take the surveyor's temporal temperature. ULP-B wrote the reading of temperature on the same paper. ULP-B did not ask surveyor any COVID-19 symptom screening questions. ULP-B then allowed the surveyor to enter the licensee's building and escorted the surveyor to the meeting room where the surveyor would be working. ULP-B advised the surveyor that registered nurse (RN)-A had to leave to complete an assessment but would return as soon as possible. RN-A was noted to be wearing a cloth neck gaiter that was pulled up over RN-A's mouth and nose. RN-A was not wearing any type of eye protection.

During entrance conference on August 30, 2022, at 1:15p.m., licensed assisted living director (LALD)-D stated he had recently viewed the community COVID-19 transmission levels and was aware that staff are to screen for symptoms of COVID-19 when allowing staff and visitors into the building.

During observation on August 30, 2022, at

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 32183 | A. BUILDING: ______ B. WING ______ | 08/31/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SUNRISE VIEW ASSISTED LIVING** | **603 LOUISIANA AVENUE ADRIAN, MN 56110** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 0 510 | Continued From page 8<br>approximately 11:50 a.m., R1 sat in the common area watching television with R3. Director of maintenance (DM)-F approached R1 wearing a mask over his nose and mouth. DM-F began speaking to R1 and in the process removed mask and placed mask below his chin. Elastic bands placed around the ears and used to keep mask over mouth and nose were noted to still be around both ears.<br><br>The Minnesota Department of Health's COVID-19 PPE and Source Control Grids dated April 7, 2022, indicated all employees who work in a congregated health care setting, including assisted living facilities, are recommended to wear a face mask when in areas they could encounter residents.<br><br>The Centers for Disease Control and Prevention (CDC) community transmission level for the week of August 25, 2022, indicated the transmission level for Nobles County was at a low level of transmission. The CDC recommends when COVID-19 level is low, health care staff are required to wear a high-quality mask or respirator (e.g. N95 mask) when indoors.<br><br>The licensee's Infection Control policy was requested but not received.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Two (2) days | 0 510 | | |
| 0 660 SS=F | 144G.42 Subd. 9 Tuberculosis prevention and control<br><br>(a) The facility must establish and maintain a | 0 660 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 32183 | A. BUILDING: ______ B. WING ______ | 08/31/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNRISE VIEW ASSISTED LIVING | 603 LOUISIANA AVENUE ADRIAN, MN 56110 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 0 660 | Continued From page 9<br>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>Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a facility TB risk assessment.<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, 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).<br><br>The findings include:<br><br>During the entrance conference on August 30, 2022, at approximately 1:40 p.m., the surveyor requested to review the facility TB risk | 0 660 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 32183 | A. BUILDING: ______ B. WING ______ | 08/31/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SUNRISE VIEW ASSISTED LIVING** | **603 LOUISIANA AVENUE ADRIAN, MN 56110** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 0 660 | Continued From page 10<br>assessment. Licensed assisted living director (LALD)-D stated a facility TB risk assessment was completed but would need to look for a copy of the form.<br><br>On August 30, 2022, at approximately 1:25 p.m., registered nurse (RN)-A brought to surveyor a copy of the licensee's TB risk assessment. The TB risk assessment provided was also not completed. LALD-D stated he was sure there had been one completed for the licensee because they were completed every year. LALD-D and RN-A were both unaware as to where the TB risk assessment would be placed.<br><br>The Minnesota Department of Health (MDH) guidelines, Regulations for TB Control in Minnesota Health Care Settings, dated June 10, 2019, and based on CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment performed annually.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 660 | | |
| 0 780 SS=F | 144G.45 Subd. 2 (a) (1) Fire protection and physical environment<br><br>(a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:<br><br>(1) for dwellings or sleeping units, as defined in the State Fire Code:<br>(i) provide smoke alarms in each room used for sleeping purposes;<br>(ii) provide smoke alarms outside each | 0 780 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 32183 | A. BUILDING: ______ B. WING ______ | 08/31/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SUNRISE VIEW ASSISTED LIVING** | **603 LOUISIANA AVENUE ADRIAN, MN 56110** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 0 780 | Continued From page 11 | 0 780 | | |

separate sleeping area in the immediate vicinity of bedrooms;

(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;

(iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and

(v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;

This MN Requirement is not met as evidenced by:
Based on observation and interview, the licensee failed provide smoke alarms in each sleeping room throughout the facility. This deficient condition had the ability to affect all staff and residents.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

On a facility tour on August 31, 2022, at approximately 1:15 p.m. with Licensed Assisted Living Director (LALD)-D and Maintenance Director (MD)-F it was observed that the smoke

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 32183 | A. BUILDING: ______ B. WING ______ | 08/31/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNRISE VIEW ASSISTED LIVING | 603 LOUISIANA AVENUE ADRIAN, MN 56110 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 0 780 | Continued From page 12<br>alarms were not installed in several of the rooms that were toured throughout the facility. LALD-D and MD-F both visually verified these deficient findings at the time of discovery.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 780 | | |
| 0 800 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 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>Based on observation and interview, the licensee failed to maintain 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. This deficient condition had the potential to affect all staff, residents, and visitors.<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, 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). | 0 800 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 32183 | A. BUILDING: ____ B. WING ____ | 08/31/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNRISE VIEW ASSISTED LIVING | 603 LOUISIANA AVENUE ADRIAN, MN 56110 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 0 800 | Continued From page 13<br><br>The findings include:<br><br>On a facility tour on August 31, 2022, at approximately 1:15 p.m. with Licensed Assisted Living Director (LALD)-D and Maintenance Director (MD)-F it was observed that the entry way leading to the exterior from the dining room had multiple ceiling tiles that were missing, and the remaining tiles were water damaged.<br><br>It was also observed that the ceiling was damaged and there was mold on the walls in the main floor laundry room.<br>I was also observed that multiple ceiling tiles were missing, and the remaining tiles were water damaged in the basement large storage area.<br><br>LALD-D and MD-F visually verified these deficient findings at the time of discovery.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 800 | | |
| 0 810 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;<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 | 0 810 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 32183 | A. BUILDING: ______ B. WING ______ | 08/31/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNRISE VIEW ASSISTED LIVING | 603 LOUISIANA AVENUE ADRIAN, MN 56110 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 0 810 | Continued From page 14 | 0 810 | | |

Continued From page 14

or unusual resident needs for movement or evacuation.
(c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.
(d) Fire safety and evacuation plans shall be readily available at all times within the facility.
(e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.
(f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.

This MN Requirement is not met as evidenced by:
Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements and failed to provide required employee and resident training on fire safety and evacuation. This had the potential to affect all staff, residents, and visitors.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, 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).

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 32183 | A. BUILDING: ______ B. WING ______ | 08/31/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SUNRISE VIEW ASSISTED LIVING** | **603 LOUISIANA AVENUE ADRIAN, MN 56110** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 0 810 | Continued From page 15<br><br>The findings include:<br><br>A record review and interview were conducted on August 31, 2022, at approximately 1:15 p.m. with Licensed Assisted Living Director (ILALD)-E, Licensed Assisted Living Director (LALD)-D and Maintenance Director (MD)-F on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility.<br><br>Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During interview, ILALD-E indicated that the fire safety and evacuation plan for the facility lacked these provisions.<br><br>Record review of the available documentation indicated that the fire safety and evacuation plan did not include 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. During interview, ILALD-E indicated that the fire safety and evacuation plan for the facility lacked these provisions.<br><br>Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training it initial hire. During interview, LALD-D provided a policy indicating that employees are trained annually thereafter and stated that the licensee did not have any further documentation on employee training. | 0 810 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 32183 | A. BUILDING: ____ B. WING ____ | 08/31/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SUNRISE VIEW ASSISTED LIVING** | **603 LOUISIANA AVENUE ADRIAN, MN 56110** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 0 810 | Continued From page 16<br><br>Record review of the available documentation indicated that the licensee did not provide 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. During interview, LALD-D stated that the licensee has not offered training to residents on fire safety and evacuation besides at admission. A policy on resident training for fire safety and evacuation but requested one was not able to be provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 810 | | |
| 01060 SS=E | 144G.52 Subd. 9 Emergency relocation<br><br>(a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination.<br>(b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum:<br>(1) the reason for the relocation;<br>(2) the name and contact information for the location to which the resident has been relocated and any new service provider;<br>(3) contact information for the Office of Ombudsman for Long-Term Care;<br>(4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and<br>(5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section | 01060 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 32183 | A. BUILDING: ______ B. WING ______ | 08/31/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNRISE VIEW ASSISTED LIVING | 603 LOUISIANA AVENUE ADRIAN, MN 56110 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 01060 | Continued From page 17 | 01060 | | |

144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.
(c) The notice required under paragraph (b) must be delivered as soon as practicable to:
(1) the resident, legal representative, and designated representative;
(2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and
(3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days.
(d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) of resident relocation within four days for one of one resident (R4) with record reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 32183 | A. BUILDING: ______ B. WING ______ | 08/31/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNRISE VIEW ASSISTED LIVING | 603 LOUISIANA AVENUE ADRIAN, MN 56110 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 01060 | Continued From page 18<br>The licensee's Resident Roster identified R4's date of admission was September 1, 2020, and date of emergency transfer to a local hospital for evaluation was June 29, 2022. As of the date of survey, R4 had not returned to the licensee.<br><br>R4's Nurse Progress Note dated June 29, 2022, indicated R4 was sent to the area local hospital for evaluation. R4 was then transferred to a long-term care facility in Sioux Falls, South Dakota. At that time, R4's residency with licensee was placed on hold until R4 would return.<br><br>During interview on August 30, 2022, at approximately 2:15 p.m., licensed assisted living director (LALD)-D stated R4 wanted to return to the licensee and resume assisted living services as soon as possible. LALD-D stated the licensee needed to address a transportation issue before R4 could return. LALD-D stated he was not aware that the Regional Ombudsman needed to be notified when a resident was out of the establishment for more than four days.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01060 | | |
| 01890 SS=E | 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. | 01890 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 32183 | A. BUILDING: ____ B. WING ____ | 08/31/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNRISE VIEW ASSISTED LIVING | 603 LOUISIANA AVENUE ADRIAN, MN 56110 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 01890 | Continued From page 19 | 01890 | | |

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to ensure medications were maintained with the original prescription label with legible information for one of one resident (R3) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

On August 30, 2022, at approximately 11:40 a.m., the surveyor observed the contents of the locked medication cart and verified the contents with unlicensed personnel (ULP)-B.

R3's Resurge dietary supplement bottle lacked a label indicating who the medication was for as well as directions for medication administration.

R3's Methylsulfonylmethane (MSM) dietary supplement bottle lacked a label indicating who the medication was for as well as directions for medication administration.

During an interview on August 30, 2022, at approximately 11:50 a.m., R3 stated that she purchased the bottles of MSM and Resurge at a local drug store. R3 stated her doctor prescribed

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 32183 | A. BUILDING: ____ B. WING ____ | 08/31/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SUNRISE VIEW ASSISTED LIVING** | **603 LOUISIANA AVENUE ADRIAN, MN 56110** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 01890 | Continued From page 20<br>the supplements after she had requested them.<br><br>During interview on August 30, 2022, at approximately 1:55 p.m., registered nurse (RN)-A verified R3 did purchase the supplements from a local drug store and acknowledged that the bottles did not have any identifying information or directions for use.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01890 | | |
| 02040 SS=F | 144G.81 Subdivision 1 Fire protection and physical environment<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 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>Based on record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. | 02040 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 32183 | A. BUILDING: ______ B. WING ______ | 08/31/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNRISE VIEW ASSISTED LIVING | 603 LOUISIANA AVENUE ADRIAN, MN 56110 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 02040 | Continued From page 21<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, 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).<br><br>The findings include:<br><br>A record review and interview were conducted on August 31, 2022, at approximately 1:15 p.m. with Licensed Assisted Living Director (ILALD)-E, Licensed Assisted Living Director (LALD)-D and Maintenance Director (MD)-F on the hazard vulnerability assessment for the physical environment of the facility.<br><br>Record review of the available documentation indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During interview, ILALD-E stated that licensee had not conducted a hazard vulnerability assessment of the physical environment with mitigation factors on and around the property to date at the time of survey because they felt the requirement was met the hazard vulnerability assessment was met by the one conducted in the Emergency Preparedness Manual.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 02040 | | |

MINNESOTA DEPARTMENT OF HEALTH

| | |
|---|---|
| Type: | Full |
| Date: | *08/30/22* |
| Time: | 11:00:00 |
| Report: | 1033221124 |

# Food and Beverage Establishment Inspection Report



**Location:**
Sunrise View Assisted Living
603 Louisiana Avenue
Adrian, MN56110
Nobles County, 53

**Establishment Info:**
ID #: 0038274
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 5074833337
ID #:

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

The following orders were issued during this inspection.

**3-500A Microbial Control: cooling**

**3-501.14A** ** Priority 1 **

MN Rule 4626.0385A Cool cooked TCS food: 1. within 2 hours from 135 degrees F (57 degrees C) to 70 degrees F (21 degrees C); and 2. within a total of 6 hours from 135 degrees F (57 degrees C) to 41 degrees F (5 degrees C) or less.

Container of meatballs was cooked at 2AM day of inspection. Meatballs were measured at 47F at 11AM. The meatballs did not cool to proper temperature within the required time frame.

*Corrected on Site*

**5-200B Plumbing: cross connections**

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

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

Drain tube stored in the floor drain.

*Comply By: 09/06/22*

**4-300 Equipment Numbers and Capacities**

**4-302.14** ** Priority 2 **

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

Facility does not have a test kit to measure sanitizing concentration.

*Comply By: 09/13/22*

# Food and Beverage Establishment Inspection Report



**Surface and Equipment Sanitizers**

Quaternary Ammonium: = 200 at Degrees Fahrenheit
Location: Red Bucket
Violation Issued: No

Chlorine: = 50 at Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

**Food and Equipment Temperatures**

Process/Item: Cooling
Temperature: 47 Degrees Fahrenheit - Location: Meatballs-Refrigerator (9 Hours)
Violation Issued: Yes

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: Au Gratin-Cooler
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: Steamed Carrots-Cooler
Violation Issued: No

Process/Item: Cold Holding
Temperature: 0> Degrees Fahrenheit - Location: Freezer
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: Three Door Cooler
Violation Issued: No

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

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

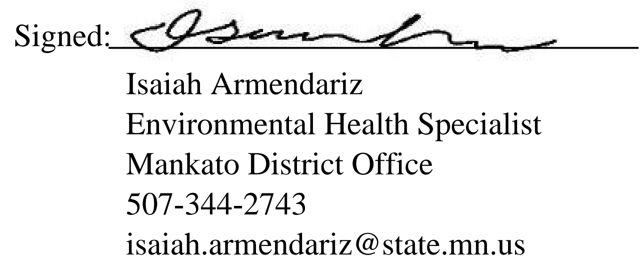
I acknowledge receipt of the inspection report number 1033221124 of 08/30/22.

Certified Food Protection Manager: Kerassia C Aslanoglov

Certification Number: FM95019 Expires: 10/06/24

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

Signed:
Kerassia C Aslanoglov

Signed:


Isaiah Armendariz
Environmental Health Specialist
Mankato District Office
507-344-2743
isaiah.armendariz@state.mn.us