



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 17, 2024

Licensee

Sunshine Wellness Center Inc.

317 5th Avenue Southeast

Minneapolis, MN 55414

RE: Project Number(s) SL37089015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 12, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. 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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility.**

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Jodi Johnson, Supervisor

State Evaluation Team

Email: jodi.johnson@state.mn.us

Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37089	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER SUNSHINE WELLNESS CENTER INC		STREET ADDRESS, CITY, STATE, ZIP CODE 317 5TH AVENUE SE MINNEAPOLIS, MN 55414			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL37089015-0 On September 10, 2024, through September 12, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were six residents; all receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all residents of the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 10, 2024, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 650 SS=D	144G.42 Subd. 8 Employee records (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	0 650			

Minnesota Department of Health

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0 650	Continued From page 2 include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content for one of two employees (clinical nurse supervisor (CNS)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: CNS-B had a hire date of April 20, 2021, and	0 650			

Minnesota Department of Health

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0 650	Continued From page 3 provided assisted living services for the licensee. On September 10, 2024, through September 11, 2024, CNS-B was observed supervising staff and assisting with care and services to the licensee's residents. CNS-B's employee record lacked evidence of: -current license or certification -annual performance review The licensee's Employee Records policy, effective date, undated, indicated the licensee would maintain a current record of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services to residents to include: -evidence of current professional licensure, registration, or certification of licensure -documentation of annual performance reviews that identify areas of improvement needed and training needs No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;	0 680			

Minnesota Department of Health

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0 680	Continued From page 4 (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to have a written emergency preparedness plan with all the required content. This had the potential to affect the six residents receiving services under the assisted living license, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on September 10, 2024, at 11:00 a.m., a request was made to	0 680			

Minnesota Department of Health

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0 680	Continued From page 5 view the licensee's emergency preparedness plan. The licensee's emergency preparedness (EP) plan, undated, lacked the following required content: -current, all-hazards approach facility assessment -description of the population served by licensee -process for EP cooperation with state and local EP officials/organizations -subsistence needs for staff and residents during an emergency -procedure for tracking staff and residents -development of all policies/procedures, based on assessment, and additional policies for: -sheltering in place -handling medical documents - process for arrangements with other facilities/providers to receive residents in the event of limitation/cessation of operations to maintain the continuity of services to residents -development of a communication plan, including primary and alternate means for communication -methods for sharing information -EP training and testing program -EP training program for staff (including documentation of training provided) -annual EP testing requirements -process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response. On September 12, 2024, at 12:15 p.m., the licensed assisted living director (LALD)-A stated their consultant went through the EP but did not inform them to add information specific to their facility. LALD-A stated they were under the impression that it was complete and thorough. LALD-A ensured the licensee would have a thorough program in place that was specific to the	0 680			

Minnesota Department of Health

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0 680	Continued From page 6 resident population and need as indicated by the facility's risk assessment. The licensee's emergency preparedness policy, effective date January 24, 2024, indicated the licensee would have an identified plan in place to assure the safety and well-being of clients and staff during periods of an emergency or disaster that disrupts services. The policy further indicated the plan would consider the organization's commitment to provide services while ensuring the safety of it's employees and clients. The policy further indicated the licensee would implement Emergency Management policy as soon as the agency became aware of the existence of an emergency. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;	0 780			

Minnesota Department of Health

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0 780	Continued From page 7 (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 to provide smoke alarms that functioned and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. 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 September 11, 2024, from approximately 12:30 p.m. to 1:30 p.m., survey staff toured the facility with maintenance (M)-E. Surveyor asked M-E to initiate a test of the smoke alarms throughout the home. Upon testing, the smoke alarms in the following locations did not sound when the test button was pressed:	0 780			

Minnesota Department of Health

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0 780	Continued From page 8 - There was no smoke alarm installed in bedroom 9. - There was no smoke alarm installed in bedroom 7. - There was no smoke alarm installed in bedroom 4. On September 11, 2024, at 1:30 p.m., M-E stated they understood the smoke alarm requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors.	0 790			

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0 790	Continued From page 9 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 11, 2024, from approximately 12:30 p.m. to 1:30 p.m., survey staff toured the facility with maintenance (M)-E. The portable fire extinguishers throughout the facility lacked records to show monthly visual inspections were complete. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher or serviced annually by a certified technician. On September 11, 2024, at 1:30 p.m., the surveyor explained to M-E that the portable fire extinguishers must be provided annual certification tags and also monthly visual inspections or "quick checks" of each extinguisher by their employees to ensure all portable extinguishers are readily available, fully charged, and operable at their designated location with no obvious physical damage or condition to the extinguisher that would prevent their operation when needed. M-E stated they understood the requirements. No further information was provided.	0 790			

Minnesota Department of Health

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0 790	Continued From page 10	0 790			
	TIME PERIOD FOR CORRECTION: Seven (7) days				
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to 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. 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 September 11, 2024, from approximately	0 800			

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0 800	Continued From page 11 12:30 p.m. to 1:30 p.m., survey staff toured the facility with maintenance (M)-E. The following was observed: Bedroom 9 was missing outlet covers throughout the space. Bedroom 7 was missing the vent grille for the ceiling air supply, the outlet near the door had a broken cover, the door strike was damaged and did not latch, and the door trim was damaged and hung off the wall. The door had a hotel-style chain lock on the inside of the room. The upstairs wood deck was heavily weathered and damaged in multiple areas. The wood threshold at the door to the deck area was soft and rotting. Anyone accessing the deck would step on the rotting threshold to step up onto the deck area. The upstairs wood deck had nails protruding from the guardrail and handrail. The wood guardrail and handrail for the stairs down to the ground were heavily weathered and rotting in multiple locations with nails protruding from the damaged wood. The siding and fascia on the back of the house under the wood deck had significant water damage. There were two locations in the siding where the surveyor could see the wall sheathing. The roof fascia was damaged adjacent to the attic balcony and porch roof. The wood rotted and fell off the building leaving openings for additional water penetration or pest penetration. On September 11, 2024, at 1:30 p.m., M-E stated they understood the above-listed deficiencies.	0 800			

Minnesota Department of Health

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0 800	Continued From page 12	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) 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.	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37089	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER SUNSHINE WELLNESS CENTER INC		STREET ADDRESS, CITY, STATE, ZIP CODE 317 5TH AVENUE SE MINNEAPOLIS, MN 55414			
(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 13 This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 11, 2024, licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Safety", dated June 13, 2023, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility.	0 810			

Minnesota Department of Health

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0 810	Continued From page 14 The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. On September 11, 2024, at 2:30 p.m., LALD-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. The policy reviewed was an unedited policy purchased from a third-party provider that was not specific to the facility. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. The provided documentation was for basic fire safety training offered by a third-party online software that could not be modified to include the facility-specific fire safety plans. LALD-A was unable to provide documentation showing any training offered or training scheduled for a future date for employees on the licensee's fire safety and evacuation plan. On September 11, 2024, at 2:30 p.m., LALD-A stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			

Minnesota Department of Health

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0 970 SS=F	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property for one of one resident (R1). This had the potential to affect all six residents residing in the facility. 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: R1 was admitted to the facility on October 1, 2021, and began receiving services under the licensee's assisted living license. On September 10, 2024, at 2:00 p.m., a copy of R1's assisted living contract was requested and	0 970			

Minnesota Department of Health

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0 970	Continued From page 16 provided. R1's Assisted Living Contract signed October 1, 2023, and updated annually, included the following language indicating a waiver of liability: -INDEMNIFICATION "Resident will indemnify and hold harmless Provider, its employees, and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury, or damage to property, arising from or out of the use by Resident of the rented premises or any other part of Provider's property, or caused wholly or in part by an act or omission of Resident or Resident's guests or agents." -LIABILITY "Provider is not liable to Resident or Resident's guests for any injury, death or property damage occurring in the Apartment Unit or on Provider's premises unless such injury, death or property damage occurred as the result of an equipment malfunction or hazardous conditions within the building not caused by Resident or Resident's guests. Provider is also not liable for any injury, death or damage occurring as the result of Resident's receipt of health-related, supportive, or other services from third party providers. Provider may be liable to Resident for its own negligent acts or those of its employees or agents. Unless caused by one of the aforementioned excepted reasons, Resident agrees to hold Provider harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the Apartment Unit or on Provider's premises." On September 10, 2024, at 12:20 p.m., clinical nurse supervisor (CNS)-B stated they were unaware of the waiver of liability clause in the	0 970			

Minnesota Department of Health

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0 970	Continued From page 17 licensee's contract and the same contract was used for all residents residing within the facility. CNS-B stated the facility would ensure all past and future contracts would not contain a waivers of liability clause within the the licensee's contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970			



Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: 09/10/24
Time: 11:00:00
Report: 1005241228

Food and Beverage Establishment Inspection Report

Page 1

Location:

Sunshine Wellness Center Inc
317 5th Avenue Se
Minneapolis, MN55414
Hennepin County, 27

Establishment Info:

ID #: 0038327
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6124041005
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.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1)

**** Priority 1 ****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

IN THE KITCHEN REFRIGERATOR, RAW SHELL EGGS WERE STORED ON THE TOP SHELF, OVER READY TO EAT FOODS INCLUDING MILK AND CHEESE. EGGS WERE MOVED TO THE BOTTOM SHELF, CORRECTED ON SITE.

Comply By: 09/10/24

Surface and Equipment Sanitizers

Utensil Surface Temp.: = at 163 Degrees Fahrenheit
Location: DISH WASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK
Temperature: 41 Degrees Fahrenheit - Location: "MAYTAG" REFRIGERATOR
Violation Issued: No

Process/Item: Cold Hold/AMBIENT
Temperature: 37 Degrees Fahrenheit - Location: "MAYTAG" REFRIGERATOR
Violation Issued: No

Type: Full
Date: 09/10/24
Time: 11:00:00
Report: 1005241228
Sunshine Wellness Center Inc

Food and Beverage Establishment Inspection Report

Page 2

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

INSPECTION COMPLETED WITH FACILITY MANAGER AND REVIEWED WITH HRD NURSING EVALUATOR MARY BRUESS.

A MAXIMUM REGISTERING THERMOMETER WAS ON SITE AND AFTER INSPECTION OPERATOR SENT INSPECTOR A PICTURE OF THE THERMOMETER THEY RAN THROUGH THEIR DISHWASHER, WHICH SHOWED IT PROVIDED A UTENSIL SURFACE TEMPERATURE OVER 160 DEGREES F.

DISCUSSED DATE MARKING, GLOVE USE, COOKING TEMPERATURES, CROSS-CONTAMINATION, AND EMPLOYEE ILLNESS.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

FLOORING IS WOOD, CABINETS ARE WOOD WITH HOLLOW BASE, COUNTERS ARE LAMINATE, AND CEILING HAS A POPCORN FINISH. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

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 1005241228 of 09/10/24.

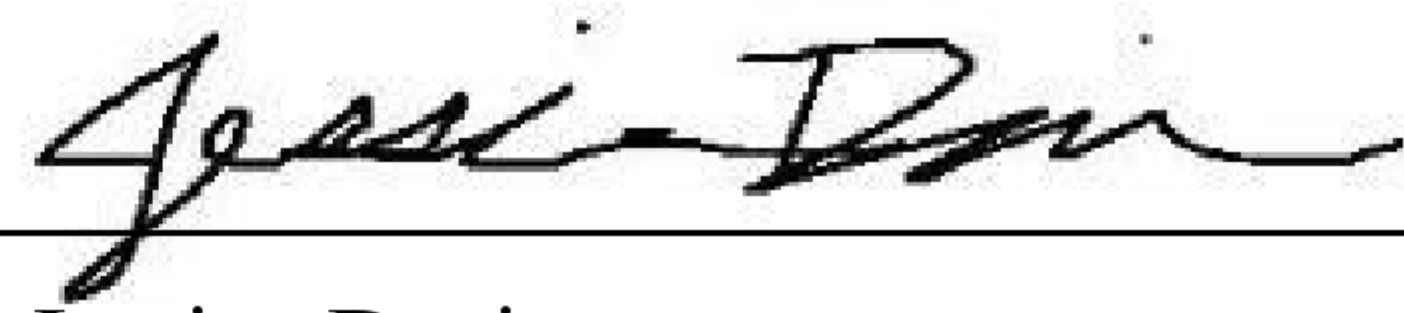
Certified Food Protection Manager KEISAN M. HUSSEIN

Certification Number: FM114519 Expires: 12/04/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

KEISAN HUSSEIN
MANAGER

Signed:  _____

Jessica Davis
Public Health Sanitarian III
651-201-3961
jessica.davis@state.mn.us