Electronically Delivered

August 12, 2022

Administrator
Sunrise Village
1125 9th Street Southeast
Willmar, MN 56201

RE: Project Number SL30451015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on July 20, 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

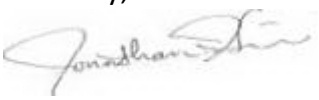
REQUESTING A HEARING

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,



Jonathan Hill, Supervisor
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State Evaluation Team
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HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30451	A. BUILDING: _____ B. WING _____	07/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE VILLAGE	1125 9TH STREET SE WILLMAR, MN 56201

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0 000	Initial Comments 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: SL30451015-0 On July 18, 2022, through July 20, 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 36 residents, all of whom received services under the provider's Assisted Living 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. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

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0 510	Continued From page 1 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control related to COVID-19. This had the potential to affect the licensee's current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Upon entrance to the facility on July 18, 2022, at approximately 10:30 a.m., the surveyor observed licensed assisted living director (LALD)-A, regional director of housing (RDOH)-B, registered nurse (RN)-C, and licensed practical nurse	0 510		

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0 510	Continued From page 2 (LPN)-H were wearing a medical-grade facemask, but no eye protection. During a facility tour with LALD-A on July 18, 2022, at approximately 11:30 a.m., the surveyor observed three unidentified staff escorting residents into the dining room for lunch and serving the residents their meal. All three staff wore a medical-grade facemask, but no eye protection. On July 18, 2022, at approximately 1;15 p.m., when the surveyor questioned the lack of eye protection, RN-C stated, "We were told back in April that we no longer needed to wear eye protection." RN-C could not recall where the information came from, but stated, "No one has been wearing them." The surveyor and RN-C looked at the Centers for Disease Control and Prevention (CDC) COVID Data Tracker, updated July 14, 2022, which revealed Kandiyohi County, Minnesota (MN) community transmission level was "high." The Minnesota Department of Health (MDH) guidance titled, "COVID-19 PPE [personal protective equipment] and Source Control Grids - for congregate care settings, by community transmission level", dated April 7, 2022, indicated during "substantial" or "high" levels of community transmission (based on the Centers for Disease Control and Prevention (CDC) online data tracking system), caregivers must wear a face mask (source control) and eye protection while working with residents without suspected or confirmed SARS-CoV-2 infection. The licensee's COVID-19 Infection Prevention Policy and Procedure policy, dated August 1, 2021, indicated the licensee would provide staff,	0 510		

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0 510	Continued From page 3 residents, and visitors with appropriate PPE according to state and federal guidelines, and PPE use, including gloves, facemasks, gowns, and eye protection, was based on availability and the latest CDC guidance. Also included, "If community transmission level is substantial or high, staff were required to wear a facemask and eye protection for all resident encounters. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for three of three residents (R1, R2, R3) with records reviewed. This practice resulted in a level two violation (a	0 630		

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0 630	Continued From page 4	0 630		

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

The findings include:

R1, R2, and R3's records lacked an individual abuse prevention plan which reviewed each resident's susceptibility to abuse by another individual, including other vulnerable adults; the resident's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that resident and other vulnerable adults.

R1
R1's diagnoses included Parkinson's Disease, asthma, congestive heart failure and claustrophobia.

R1's Service Plan, dated July 4, 2022, noted services to include bathing, dressing, medication assistance, toileting assistance, safety checks and escorts.

On July 19, 2022, at approximately 11:04 a.m., the surveyor observed while unlicensed personnel (ULP)-E administered R1's medications.

R1's Individual Abuse Prevention Plan, dated June 28, 2022, indicated R1 was at risk for falls, required full medication management, required monitoring of heart function, had shortness of breath with exertion, and required assistance in

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0 630	Continued From page 5 an emergency situation. The plan indicated R1's risk of abusive behavior was "Not known." The plan lacked a review of R1's susceptibility to abuse by another individual, including other vulnerable adults; the resident's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to R1 and other vulnerable adults. R2 R2's diagnoses included stroke, diabetes, osteoarthritis and seasonal affective disorder (major depressive disorder with seasonal pattern). R2's Service Plan, dated June 20, 2022, indicated R2 required services including medication assistance and blood glucose checks. On July 19, 2022, at approximately 11:07 a.m., the surveyor observed while ULP-E administered R2's medications. R2's Individual Abuse Prevention Plan, dated June 20, 2022, indicated R2 required review of dietary choices due to diabetic diagnosis, required medication management, was at risk for falls, required monitoring of heart function, and required assistance in an emergency situation. The plan indicated R2 had no current risk indicators for the risk of abuse toward him and indicated the risk of abusive behavior was "Not known." The plan lacked a review of R2's susceptibility to abuse by another individual, including other vulnerable adults; the resident's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to R2 and other vulnerable adults.	0 630		

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0 630	Continued From page 6 R3 R3's diagnoses included congestive heart failure, acute kidney failure with dependence on renal dialysis, muscle weakness and abnormalities of gait and mobility. R3's Service Plan, dated April 7, 2022, indicated R3 required medication management, compression stockings and safety checks twice daily. R3's Individual Abuse Prevention Plan, dated May 18, 2022, indicated R3 was at risk for falls, required full medication management, assistance with compression stockings, dietary choices monitoring due to low sodium diet and fluid restriction, monitoring of circulatory function, required assistance with financial decisions, supervision with transfers, and required assistance in an emergency situation. The plan indicated R3's risk of abusive behavior was "Not known." The plan lacked a review of R3's susceptibility to abuse by another individual, including other vulnerable adults; the resident's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to R3 and other vulnerable adults. On July 17, 2022, at approximately 1:10 p.m., registered nurse (RN)-C verified R1, R2, and R3's IAPP lacked the above required content. The licensee's Individual Abuse Prevention Plans policy, dated August 1, 2021, indicated an IAPP would be developed for each assisted living resident based on the nursing assessment and would include an individualized review or assessment of the resident's susceptibility to be abused by another individual, including other	0 630		

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0 630	Continued From page 7 vulnerable adults, the resident's risk of abusing other vulnerable adults, specific measures to minimize the risk of abuse to that person and other vulnerable adults, and measures to minimize the risk of self-abuse, if applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=E	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 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. (b) Each employee record must be retained for at least three years after a paid employee,	0 650		

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0 650	Continued From page 8 volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. 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 two of four employees (registered nurse (RN)-C, unlicensed personnel (ULP)-D) 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: RN-C RN-C had a start date of August 23, 2021. RN-C's record lacked evidence of the following: -records of orientation. ULP-D ULP-D had a hire date of September 15, 2015, and began providing services under the licensee's Assisted Living license on August 1, 2021. ULP-D's record included an Annual Review,	0 650		

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0 650	Continued From page 9 dated December 15, 2019, and signed by ULP-D on January 2, 2020. ULP-D's record lacked evidence of the following: -documentation of annual performance reviews that identify areas of improvement needed and training needs. On July 20, 2022, at approximately 9:30 a.m., human resources director (HRD)-I verified the above missing documents and stated RN-C's orientation was completed and included all of the required content; however, did not have all of the required contents documented in her employee record. In addition, HRD-I verified ULP-D's most recent performance evaluation was completed over two years ago, instead of annually as required, and indicated the process for annual performance evaluations was "paused" during the pandemic; however, there was a plan to complete them on the employees' anniversary date. The licensee's Personnel Records policy, dated August 1, 2021, noted the personnel file would include a record of orientation and performance evaluations which identify areas of improvement needed and training needs. The licensee's Performance Review Policy, dated August 1, 2021, indicated the licensee would conduct a performance review on staff annually on the employee's anniversary date to review the employee's feedback, review the supervisor's assessment of the employee's performance, and discuss goals for the upcoming period. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		

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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. 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	0 810		

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0 810	Continued From page 11	0 810		

evacuation plan with required elements and failed to provide required employee training on fire safety and evacuation. 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).

Findings include:

A record review and interview were conducted on July 20, 2022, at approximately 1:20 p.m. with Licensed Assisted Living Director (LALD)-A, Regional Director of Housing (RDOH)-B, and Facilities Director (FD)-F on the fire safety and evacuation plan, fire safety, and evacuation training, and evacuation drills for the facility.

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, LALD-A stated that they were not able to locate these provisions in the fire safety and evacuation plan.

Record review of available documentation indicated that the licensee provided training annually only and did not provide employee training on the fire safety and evacuation plan twice per year after the training at initial hire. During interview, LALD-A stated that training is

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	30451	A. BUILDING: _____ B. WING _____	07/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE VILLAGE	1125 9TH STREET SE WILLMAR, MN 56201

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0 810	Continued From page 12 provided annually per policy. Record review of the available documentation indicated that the licensee did not conduct evacuation drills every other month as required by statute. During interview, FD-F stated that the licensee had not begun conducting drills at this facility since the requirement went into effect. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency	01650		

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01650	Continued From page 13 medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan included the required content for one of three residents (R2) 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 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: R2's service plan lacked the following: - the schedule of monitoring assessments of the resident. On July 19, 2022, at approximately 11:07 a.m., the surveyor observed while ULP-E administered R2's medications. R2's Service Plan, dated June 20, 2022, indicated R2 required services including medication assistance and blood glucose checks. The Service Plan incorrectly indicated the licensee provided services under the Minnesota Comprehensive Home Care license, instead of the Assisted Living licensure, therefore, lacked the required content noted above.	01650		

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01650	Continued From page 14 On July 19, 2022, at approximately 1:06 p.m., registered nurse (RN)-C confirmed the service plan for R2 lacked the required content noted above and stated the service plan was not printed in the correct format, therefore, the information above was not included. The licensee's Contents of Service Plans policy, dated August 1, 2021, indicated the service plan would identify the description of the services provided, fees for services, the schedule and methods of monitoring assessment of the resident, the schedule and methods of monitoring staff providing services, and the plan for contingency action that included what actions would be taken if the scheduled services cannot be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure prescription medications were securely locked in a substantially constructed compartment and permitted only authorized personnel to have	01880		

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01880	Continued From page 15 access for one of three residents (R6) reviewed for storage of medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on July 18, 2022, at approximately 10:45 a.m., registered nurse (RN)-C confirmed the licensee provided medication management services to 22 of the licensee's 36 current residents, which included medications prepared in punch packs and/or medication setup by the RN into medication planner boxes (a plastic medication box with designated compartments for days and times), for later administration by unlicensed personnel (ULP). RN-C indicated medications were securely stored in a locked medication box located in the residents' apartments, with only staff having access with keys. R6's diagnoses included schizoaffective disorder, depressive type (mental disorder with a combination of symptoms of schizophrenia and mood disorder, with major depressive episodes), glaucoma both eyes, seizure disorder and back pain. R6's Assessment As Of Date, dated June 13, 2022, indicated R6 required full management of medications, set-up, administration and ordering,	01880		

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01880	Continued From page 16 and noted medications were stored in a locked box. R6's physician orders, printed July 19, 2022, included four medications to treat depression and schizophrenia, a sleep aid, two supplements, one medication to prevent seizures, one medication to prevent blood clots, one medication to treat allergies, one antispasmodic medication, four eye drops to treat glaucoma and one medication for low blood pressure. On July 19, 2022, at approximately 12:12 p.m., the surveyor observed while unlicensed personnel (ULP)-D entered R6's room, washed her hands and prepared to give R6's medications. ULP-D stated R6 kept her medications on her dining room table, "per her choice." The surveyor observed several medication planner boxes on the table and a basket with medication punch packs. ULP-D located the medication planner box labeled for the noon medications, verified the medications on the electronic medical record, dumped the medications into a medication cup, and handed the medication cup to R6. R6 brought the cup to her mouth and swallowed the medications with liquid from a cup. On July 19, 2022, at approximately 1:38 p.m., RN-C stated R6 refused to allow staff to lock her medications in the locked box and stated, "She freaks out." RN-C stated they had an agreement with R6 that her door must always be locked when leaving her room, although RN-C could not verify that R6 always locked her door. RN-C verified the medications were not stored in a substantially constructed compartment to keep medications secure, as required. The licensee's Storage of Medications policy,	01880		

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01880	Continued From page 17 dated August 1, 2021, indicated the RN would "recommend where medications should be stored in the resident's home in the resident's individualized medication management plan, understanding that our agency may not be able to control where and how a resident stores his/her medications in the home." Also included, "When secured storage of the medications is necessary, the RN will identify where the medications will be stored, how they will be secured or locked under proper temperature controls and who has access to the medications." The policy lacked direction that the licensee must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access, as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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

Type: Full
Date: *07/18/22*
Time: 13:51:11
Report: 8042221124

Food and Beverage Establishment Inspection Report

Location:
Sunrise Village
1125 9th Street Se
Willmar, MN56201
Kandiyohi County, 34

Establishment Info:
ID #: 0037897
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3202351602
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

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

PROVIDE A WAY TO MEASURE THE WATER TEMPERATURE AT PLATE LEVEL. THERMOMETER OBTAINED DURING INSPECTION.

Corrected on Site

Surface and Equipment Sanitizers

Hot Water: = at 167 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 158 Degrees Fahrenheit - Location: HAMBURGER
Violation Issued: No

Process/Item: Hot Holding
Temperature: 167 Degrees Fahrenheit - Location: BAKED BEANS
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: WHIPPED CREAM
Violation Issued: No

Type: Full
Date: *07/18/22*
Time: 13:51:11
Report: 8042221124
Sunrise Village

Food and Beverage Establishment Inspection Report

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	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 Minnesota Department of Health inspection report number 8042221124 of 07/18/22.

Certified Food Protection Manager: MARY HENKEL

Certification Number: 90450 Expires: 08/18/23

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: EH
Erin Hodgins
Public Health Sanitarian
651-201-4500
health.foodlodging@state.mn.us