Electronically Delivered

October 1, 2025

Licensee
Sunflower Homes Health LLC
901 Redwell Lane
Apple Valley, MN 55124

RE: Project Number(s) SL40861015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on July 30, 2025, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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

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

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

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

The total amount you are assessed is $500.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per 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 residents/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.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

To submit a hearing request, please visit: **https://forms.web.health.state.mn.us/form/HRDAppealsForm**.

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40861	A. BUILDING: _____ B. WING _____	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNFLOWER HOMES HEALTH LLC	901 REDWELL LANE APPLE VALLEY, MN 55124

(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: SL40861015-0 On July 28, 2025, through July 30, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there was one resident; one receiving services under the Provisional Assisted Living Facility 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 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A,	0 480		

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0 480	Continued From page 2 existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 28, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (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. (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 complies with accepted health care, medical and nursing standards for infection control related to glove use and handwashing during medication administration by one of one employee (owner/unlicensed personnel (O/ULP)-A). This had the potential to affect the licensee's one resident. 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	0 510		

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0 510	Continued From page 4 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 August 28, 2025, at 12:56 p.m., the surveyor observed O/ULP-A apply gloves and remove R1's pre-packaged medications from the medication file cabinet. O/ULP-A prepared R1's medications and placed them into a medication cup. O/ULP-A gathered R1's diabetic supplies and R1's medications and brought them to R1's room. O/ULP-A then started to prepare to check R1's blood sugar. O/ULP-A stated he forgot alcohol swabs and left R1's room to get alcohol swabs. O/ULP-A returned and checked R1's blood sugar and administered R1's oral medications. O/ULP-A returned to the dining room and removed an insulin pen from the mini refrigerator. O/ULP-A brought the insulin pen to R1's room, prepared the insulin pen and administered it in R1's abdomen. O/ULP-A returned to the dining room, documented administration of medications, removed gloves and washed his hands. O/ULP-A wore the same pair of gloves while performing all of the above tasks. On August 28, 2025, at 1:15 p.m., O/ULP-A stated he should have removed his gloves and performed hand hygiene between tasks. The licensee's Hand Washing policy dated June 1, 2024, indicated handwashing would be performed by all employees, as necessary, between tasks and procedures, and after bathroom use, to prevent cross-contamination.	0 510		

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0 510	Continued From page 5 No other 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 the licensee's one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 630		

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0 630	Continued From page 6 The findings include: R1 was admitted on May 2, 2025, with diagnoses that included diabetes and hypertension (high blood pressure). R1's service plan dated May 8, 2025, indicated R1 received services to include dressing, grooming, bathing, toileting, standby assistance, blood sugar checks, and medication administration. On July 28, 2025, at 12:56 p.m., the surveyor observed owner/unlicensed personnel (O/ULP)-A administer medications to R1. R1's record lacked an IAPP to include the following required content: -individualized review r assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults -the person's risk of abusing other vulnerable adults -statements f the specific measures to be taken t minimize the risk of abuse to that person and other vulnerable adults On July 29, 2025, at 7:47 a.m., clinical nurse supervisor (CNS)-B reviewed R1's medical record and stated it did not include an IAPP. CNS-B stated she was newly hired for the licensee and was unsure why the previous nurse did not complete an IAPP for R1. The licensee's Individual Abuse Prevention Plan policy dated June 1, 2024, indicated the licensee would develop and implement ad IAPP for each vulnerable adult. The plan would contain an individualized review or assessment of the	0 630		

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0 630	Continued From page 7 person's susceptibility to abuse by another individual, including: a. Other vulnerable adults b. The person's risk of abusing other vulnerable adults, and c. Statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention program, based on the most current	0 660		

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0 660	Continued From page 8 guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a completed health history and symptom screening and failed to complete a two-step TST (tuberculin skin test) or other evidence of tuberculosis (TB) screening such as a blood test for one of two employees (unlicensed personnel (ULP)-C). This had the potential to affect the licensee's one resident. This practice resulted in a level two violation (a violation that did no 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: ULP-C was hired on July 20, 2025, to provide direct care and services to the licensee's residents. ULP-C's employee record lacked evidence of the following: -TB history and symptom screening -Two-step TST or other evidence of TB screening such as a blood test. On July 29, 2025, at 8:14 a.m., owner (O)/ULP-A stated ULP-C's employee record did not include a TB history and symptom screening or evidence of TB testing. O/ULP-A stated ULP-C was scheduled for a blood test later this week. The licensee's Tuberculosis Screening policy dated June 1, 2024, indicated screening for	0 660		

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0 660	Continued From page 9 employees would be conducted as follows: -new staff will be screened for active signs of TB using the Baseline TB Screening Tool -new staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB screening Tool -no staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is revived and documented No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must	0 680		

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0 680	Continued From page 10 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 observation, interview, and record review, the licensee failed to have a written emergency preparedness (EP) plan with all of the required content. This had the potential to affect all residents, staff, and visitors 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's 2025 Emergency Operations Preparedness Plan was reviewed and lacked the following: - arrangement with other faculties - policy and procedure for a system to track the location of on duty staff and sheltered residents and if on duty staff and sheltered residents are relocated, the facility must document the specific name/location of the receiving facility or other location;	0 680		

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0 680	Continued From page 11 - policy and procedure addressing system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - policy and procedure addressing use of volunteers, including the process/role for integration On July 29, 2025, at 9:44 a.m., owner/unlicensed personnel (O/ULP)-A and clinical nurse supervisor (CNS)-B reviewed the licensee's emergency preparedness binder and stated it lacked the required content as listed above. The licensee's Emergency Preparedness Plan-Appendix Z Compliance policy dated June 1, 2024, indicated the emergency preparedness plan would include all required elements of appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 690 SS=F	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure entries were authenticated by the name and title of the person	0 690		

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	40861	A. BUILDING: _____ B. WING _____	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNFLOWER HOMES HEALTH LLC	901 REDWELL LANE APPLE VALLEY, MN 55124

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0 690	Continued From page 12 making the entry in for the licensee's one resident record (R1). 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 on May 2, 2025, with diagnoses that included diabetes and hypertension (high blood pressure). R1's service plan dated May 8, 2025, indicated R1 received services to include dressing, grooming, bathing, toileting, standby assistance, blood sugar checks, and medication administration. On July 28, 2025, at 12:56 p.m., the surveyor observed owner/unlicensed personnel (O/ULP)-A administer medications to R1. R1's medication administration record (MAR) dated July 2025, included staff initials but lacked staff names/signatures and credentials/title. R1's Services received document dated July 2025, included staff initials but lacked staff names/signature and credentials/title for all staff who documented services completed for R1.	0 690		

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0 690	Continued From page 13 R1's progress notes entries dated May 2025, through July 2025, did not include authentication by the name and title of the person making the entry. On July 29, 2025, at 7:51 a.m., clinical nurse supervisor (CNS)-B reviewed R1's MAR, progress notes and services reviewed document and stated they did not include authentication by the person making the entry. The licensee's Resident Record- Information and Content policy dated June 1, 2024, indicated all entries in the resident records must be current, legible, permanently recorded, dated and authenticated with the name and title of the person making the entry. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a	0 900		

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0 900	Continued From page 14 complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a written contract with the required content for the licensee's one resident (R1). 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 on May 2, 2025, with diagnoses	0 900		

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0 900	Continued From page 15 that included diabetes and hypertension (high blood pressure). R1's service plan dated May 8, 2025, indicated R1 received services to include dressing, grooming, bathing, toileting, standby assistance, blood sugar checks, and medication administration. R1's Assisted Living Contract was signed by R1 and the licensee on May 8, 2025, six days after R1 was admitted and started receiving services. On July 29, 2025, at 7:53 a.m., owner/unlicensed personnel (O/ULP)-A reviewed R1's contract and stated it was not signed prior to providing services to R1. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
01470 SS=E	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff	01470		

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01470	Continued From page 16 responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication	01470		

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01470	Continued From page 17 access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of two employees (unlicensed personnel (ULP)-C and owner (O)/ULP-A) received orientation to assisted living facility licensing requirements and regulations before providing services. 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: ULP-C ULP-C was hired on July 20, 2025, to provide direct care and services to the facility's residents. ULP-C's employee record did not include the following required orientation content: - Assisted Living Bill of Rights O/ULP-A O/ULP-A was hired on April 1, 2025, to provide direct care and services to the facility's residents.	01470		

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01470	Continued From page 18 O/ULP-A's employee record did not include the following required orientation content: - Assisted Living Bill of Rights On July 29, 2025, at 9:01 a.m., clinical nurse supervisor (CNS)-B reviewed ULP-C and O/ULP-A's employee record and stated there was no evidence the training listed above was completed. CNS-B stated the licensee was working on changing their training program to ensure all training requirements were met. The licensee's Orientation of Staff and Supervisors and Content policy dated June 1, 2024, indicated employees must complete the orientation to assisted living facility requirements before providing assisted living services to residents. The orientation must contain the following topics: -An overview of appropriate Assisted living statues and rules -The assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights -Handling of residents' complaints, reporting of complains, and where to report complains, including information on the Office of Health Facility Complaints -Consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, count-managed care advocates, or other relevant advocacy services No further information was provided.	01470		

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01470	Continued From page 19 TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01470		
01530 SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the	01530		

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01530	Continued From page 20 new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of one employee (owner/unlicensed personnel (O/ULP)-A) received the required amount of mental illness, and de-escalation training in the required time frame. 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: The licensee provided services under an Assisted Living Facility license. O/ULP-A was hired on April 1, 2025, to provide direct care and services to the licensee's residents. O/ULP-A's employee record lacked evidence of completing any mental illness, and de-escalation	01530		

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01530	Continued From page 21 training. On July 29, 2025, at 9:07 a.m., clinical nurse supervisor (CNS)-B reviewed O/ULP-A's record and stated it did not include the required mental illness, and de-escalation training as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan.	01640		

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01640	Continued From page 22 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for the licensee's one resident (R1). 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 on May 2, 2025, with diagnoses that included diabetes. On July 28, 2025, at 12:56 p.m., the surveyor observed owner/unlicensed personnel (O/ULP)-A administer medications to R1. R1's service plan dated May 8, 2025, indicated R1 received services to include dressing, grooming, bathing, toileting, standby assistance, blood sugar checks, and medication administration. R1's service plan did not include daily blood pressure checks. R1's medication administration record (MAR) dated July 2025, included: -blood pressure checks daily	01640		

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01640	Continued From page 23 R1's record lacked prescriber orders for daily blood pressure checks. On July 29, 2025, at 8:11 a.m., clinical nurse supervisor (CNS)-B reviewed R1's service plan and stated it did not include daily blood pressure checks. CNS-B stated a previous nurse completed R1's service plan and was unsure why blood pressure checks wasn't listed as a current service. The licensee's Service Plan policy dated June 1, 2024, indicated the service plans and any revisions or updates shall be entered into the resident's record, including notice of change in fees when applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based	01730		

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01730	Continued From page 24 on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with the required content for the licensee's one resident (R1).	01730		

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01730	Continued From page 25 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: During the entrance conference on July 28, 2025, at 10:10 a.m., owner/unlicensed personnel (O/ULP)-A stated the licensee provided medication management services to the residents and medications were stored in a file cabinet and a mini refrigerator located in the dining room. R1 was admitted on May 2, 2025, with diagnoses that included diabetes and hypertension (high blood pressure). R1's service plan dated May 8, 2025, indicated R1 received services to include dressing, grooming, bathing, toileting, standby assistance, blood sugar checks, and medication administration. On July 28, 2025, at 12:56 p.m., the surveyor observed O/ULP-A administer oral medications and insulin which was obtained from the mini refrigerator to R1. R1's medication management plan dated May 15, 2025, indicated: -all medications are secured in locked medication carts/rooms.	01730		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNFLOWER HOMES HEALTH LLC	901 REDWELL LANE APPLE VALLEY, MN 55124

(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
01730	Continued From page 26 On July 29, 2025, at 8:04 a.m., clinical nurse supervisor (CNS)-B stated the licensee did not utilize medication carts or have a medication room. CNS-B stated the file cabinet stored all medications except for medications that required refrigeration, in which those would be stored in the mini refrigerator. CNS-B stated a previous nurse completed R1's medication management plan and she would update it to reflect accurate medication storage. The licensee's Medication Management Individualized Plan policy dated September 1, 2023, indicated the licensee would develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: a. a statement describing the medication management services that will be provided b. a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions c. documentation of specific resident instructions relating to the administration of medications d. identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis e. identification of medication management tasks that may be delegated to unlicensed personnel f. procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services, and g. any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered	01730		

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01730	Continued From page 27 as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure insulin via a prefilled insulin pen was administered according to manufacturer instructions by one of one employee (owner/unlicensed personnel (O/ULP-A). 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	01750		

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01750	Continued From page 28 residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted on May 2, 2025, with diagnoses that included diabetes and hypertension (high blood pressure). R1's service plan dated May 8, 2025, indicated R1 received services to include dressing, grooming, bathing, toileting, standby assistance, blood sugar checks, and medication administration. R1's signed prescriber orders dated July 7, 2025, included: -insulin glargine 100 unit/ml; inject 20 units subcutaneously daily On July 28, 2025, at 12:56 p.m., O/ULP-A obtained R1's insulin glargine pen and dialed the pen to the prescribed 20 units without priming the pen first. O/ULP-A then administered the insulin into R1's abdomen. On July 28, 2025, at 1:06 p.m., O/ULP-A stated he forgot to prime the insulin pen prior to dialing the prescribed dose. On July 29, 2025, at 8:07 a.m., clinical nurse supervisor (CNS)-B stated she expected the ULP to prime the insulin pen with two units prior to dialing the prescribed dose. The manufacturer instructions for use for the insulin glargine insulin pen dated August 2022, indicated the following:	01750		

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01750	Continued From page 29 Step 3: Dial a test dose of 2 units. Hold pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. This will help you get the most accurate dose. Press the inject button all the way in and check to see that insulin comes out of the needle. The dial will automatically go back to zero after you perform the test. If no insulin comes out, repeat the test two more times. If there is still no insulin coming out, use a new needle and do the safety test again. Step 4: Make sure the window shows "0" and then select the desired dose. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by:	01760		

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01760	Continued From page 30 Based on observation, interview, and record review, the licensee failed to ensure medications were administered per prescriber's orders for the licensee's one resident (R1). 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 on May 2, 2025, with diagnoses that included diabetes and hypertension (high blood pressure). On July 28, 2025, at 12:56 p.m., the surveyor observed owner/unlicensed personnel (O/ULP)-A administer medications to R1. R1's service plan dated May 8, 2025, indicated R1 received services to include medication administration. R1's record contained an After Visit Summary (AVS) dated July 7, 2025, included an unsigned, medication list which included: -aspirin 81 milligrams (mg); take one tablet by mouth daily R1's medication administration record (MAR) dated July 2025, did not include aspirin 81 mg. On July 29, 2025, at 7:54 a.m., clinical nurse	01760		

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01760	Continued From page 31 supervisor (CNS)-B stated the aspirin order was new from R1's appointment on July 7, 2025. CNS-B reviewed R1's MAR and stated it did not include aspirin. CNS-B stated the aspirin order was not processed and R1 had not yet received it. CNS-B stated she would notify the pharmacy, update R1's record, and start the aspirin once delivered from the pharmacy. The licensee's Medication and Treatment Orders-Implementing dated June 1, 2024, indicated medication and treatment/therapy orders received by the licensee must be implemented within 24 hours of receipt. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for all medications the provider managed for the licensee's one resident (R1). 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	01820		

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01820	Continued From page 32 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 was admitted on May 2, 2025, with diagnoses that included diabetes and hypertension (high blood pressure). On July 28, 2025, at 12:56 p.m., the surveyor observed owner/unlicensed personnel (O/ULP)-A administer medications to R1. R1's service plan dated May 8, 2025, indicated R1 received services to include medication administration. R1's record contained an undated and unsigned, "Medication and Treatment/Therapy Orders" document that included the following medication orders: -acetaminophen 325 milligrams (mg); take three tablets (975 mg) by mouth daily as needed for pain -amlodipine 2.5 mg take one tablet by mouth daily (blood pressure) -Vitamin D3 50 micrograms (mcg); take one tablet by mouth daily (supplement) -potassium chloride 10 milliequivalents (mEq); take one tablet by mouth daily (supplement) -atorvastatin 10 mg; take one tablet by mouth daily at bedtime (cholesterol) -furosemide 40 mg; take one tablet by mouth daily (diuretic) -lisinopril 40 mg; take one tablet by mouth daily	01820		

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01820	Continued From page 33 (blood pressure) -ferrous gluconate 324 mg; take one tablet by mouth daily (supplement) -Jardiance (empagliflozin) 25 mg; take one tablet by mouth daily (blood thinner) -insulin glargine 100 units/3 milliliters (ml); inject 15 units subcutaneously two times daily (diabetes) -Ozempic (semaglutide) 2 mg/3 ml; inject 0.5 mg subcutaneously once a week for four weeks. Administer on Fridays start May 2, 2025 (diabetes) -bisacodyl suppository 10 mg; insert one suppository, rectally once a day as needed (constipation) -polyethylene glycol 17 grams (g); take 17 g oral once a day as needed (constipation) -senna-docusate 8.6-50 mg; take one tablet by mouth two times daily as needed (constipation) R1's medication administration record (MAR) dated May 2025, indicated R1 first received medications administered by staff on the evening of May 2, 2025; however, R1's signed prescriber orders were not received until July 7, 2025. R1's MAR dated July 2025, included the following medications: -semaglutide 8 mg/3 ml; inject 2 mg subcutaneously once a week -lisinopril 40 mg; take one tablet by mouth once daily -insulin glargine 100 units/ml; inject 20 units subcutaneously -empagliflozin 25 mg; take one tablet by mouth once daily -furosemide 40 mg; take one tablet by mouth once daily -amlodipine 2.5 mg; take one tablet by mouth	01820		

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01820	Continued From page 34 once daily -ferrous gluconate 324 mg; take one tablet by mouth once daily -Vitamin D 50 micrograms mcg; take one tablet by mouth once daily -potassium chloride 10 mEq; take one tablet by mouth once daily -atorvastatin calcium 10 mg; take one tablet by mouth daily R1's MAR did not include the following medications: acetaminophen, bisacodyl suppository, polyethylene glycol or senna-docusate. R1's signed prescriber orders dated July 7, 2025, included: -semaglutide 8 mg/3 ml: inject 2 mg subcutaneously once a week -lisinopril 40 mg; take one tablet by mouth daily -insulin glargine 100 unit/ml; inject 20 units subcutaneously daily -empagliflozin 25 mg; take one tablet by mouth daily -furosemide 40 mg; take one tablet by mouth daily - amlodipine 2.5 mg; take one tablet by mouth daily -ferrous gluconate 324 mg; take one tablet by mouth daily -Vitamin D2 50 mcg; take note tablet by once daily -potassium chloride 10 mEq; take one capsule by mouth once daily -atorvastatin calcium 10 mg; take one tablet by mouth daily R1's signed prescriber orders did not include orders for acetaminophen, bisacodyl suppository,	01820		

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01820	Continued From page 35 polyethylene glycol or senna-docusate. On July 29, 2025, at 7:54 a.m., clinical nurse supervisor (CNS)-B stated the Medication and Treatment/Therapy Orders document was used to obtain prescriber orders upon a resident admission. CNS-B stated the nurse that admitted R1 no longer worked at the licensee and was unsure if R1's medication and treatment/therapy orders were faxed to R1's primary care provider (PCP) or not. CNS-B stated she was newly hired by the licensee and noticed R1 did not have signed prescriber orders and requested orders from R1's PCP to be sent to the licensee and pharmacy. R1's signed prescriber orders dated July 7, 2025, (listed above) were returned. CNS-B reviewed R1's orders dated July 7, 2025, and stated it did not include PRN (as needed) orders for acetaminophen, bisacodyl suppository, polyethylene glycol or senna-docusate. CNS-B stated she would contact R1's PCP and request signed orders for the PRN medications. The licensee's Medication and Treatment Orders policy dated September 1, 2023, indicated residents who received medication management services by the licensee will have a current physician prescribed medication or treatment/therapy orders on record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and	01880		

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01880	Continued From page 36 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 all medications were securely locked in substantially constructed compartments and permitted only authorized personnel to have access. This had the potential to affect the licensee's one resident, 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 of the residents). The findings include: On July 28, 2025, at approximately 10:10 a.m. during the entrance conference, owner/unlicensed personnel (O/ULP)-A stated medications were stored in a file cabinet and mini refrigerator located in the dining room. On July 28, 2025, at 12:56 p.m., the surveyor observed O/ULP-A remove R1's medications and diabetic supplies from the locked file cabinet to prepare for administration. O/ULP-A brought R1's medications to her room, leaving the file cabinet drawer open and the keys in the lock. O/ULP-A administered R1's medications and checked her blood sugar. O/ULP-A returned the dining room,	01880		

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01880	Continued From page 37 disposed used diabetic supplies and remove one insulin pen from the mini refrigerator. The refrigerator did not have a lock on it. O/ULP-A prepared R1's insulin pen and brought it to R1's room to be administered. The file cabinet was still open, and the keys remained in the lock. O/ULP-A returned to the dining room, documented the administration of medications, washed his hands and then shut and locked the file cabinet placing the keys in his pocket. On July 29, 2025, at 8:06 a.m., clinical nurse supervisor (CNS)-B stated the file cabinet should be locked when not in use, and the key should never be left in the lock without staff present. O/ULP-A stated the mini refrigerator did not have a lock on it but one had been ordered. The licensee's Medication Storage policy dated September 1, 2023, indicated when medications are managed and stored by the licensee, medications will be kept securely locked ad stored per manufacturer's directions. Only authorized staff will have access to stored medications. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services	01940		

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01940	Continued From page 38 that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for the licensee's one resident (R1). 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	01940		

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01940	Continued From page 39 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 was admitted on May 2, 2025, with diagnoses that included diabetes and hypertension (high blood pressure). R1's service plan dated May 8, 2025, indicated R1 received services to include dressing, grooming, bathing, toileting, standby assistance, blood sugar checks, and medication administration. On July 28, 2025, at 12:56 p.m., the surveyor observed owner/unlicensed personnel (O/ULP)-A check R1's blood sugar and administer medications to R1. R1's medication administration record (MAR) dated July 2025, included: -check blood glucose twice a day -blood pressure check once a day R1's record lacked prescriber orders for twice daily blood glucose checks and daily blood pressure checks. R1's Treatment and Therapy Plan dated May 15, 2025, lacked the following required content: - statement of the type of service that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that	01940		

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01940	Continued From page 40 will be delegated to unlicensed personnel; - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On July 29, 2025, at 8:08 a.m., clinical nurse supervisor (CNS)-B reviewed R1's treatment plan and stated it did not include the required content as listed above. CNS-B stated she was recently hired for the licensee and did not know why the previous nurse did not include the required content as required. The licensee's Treatment and Therapy Management Plan dated September 1, 2023, indicated a current individualized treatment and therapy management record for each resident which must contain at least the following: a. a statement of the type of services that will be provided b. documentation of specific resident instructions relating to the treatments or therapy administration c. identification of treatment or therapy tasks that will be delegated to unlicensed personnel d. procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services e. any resident-specific requirements relating to documentation of treatment and therapy received f. verification that all treatment and therapy was administered as prescribed g. monitoring of treatment or therapy to prevent possible complications or adverse reactions The treatment or therapy management record	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40861	A. BUILDING: _____ B. WING _____	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNFLOWER HOMES HEALTH LLC	901 REDWELL LANE APPLE VALLEY, MN 55124

(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
01940	Continued From page 41 must be current and updated when there are ay changes No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01970 SS=F	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for the licensee's one resident (R1) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40861	A. BUILDING: _____ B. WING _____	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNFLOWER HOMES HEALTH LLC	901 REDWELL LANE APPLE VALLEY, MN 55124

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01970	Continued From page 42 R1 was admitted on May 2, 2025, with diagnoses that included diabetes and hypertension (high blood pressure). R1's service plan dated May 8, 2025, indicated R1 received services to include dressing, grooming, bathing, toileting, standby assistance, blood sugar checks, and medication administration. On July 28, 2025, at 12:56 p.m., the surveyor observed owner/unlicensed personnel (O/ULP)-A check R1's blood sugar and administer medications to R1. R1's medication administration record (MAR) dated July 2025, included: -check blood glucose twice a day -blood pressure check once a day R1's record lacked prescriber orders for twice daily blood glucose checks and daily blood pressure checks. On July 29, 2025, at 8:10 a.m., clinical nurse supervisor (CNS)-B stated R1's record lacked prescriber orders for blood glucose and blood pressure checks. CNS-B stated R1 is waiting for her Dexcom (machine that continuously checks blood glucose) to arrive and then the staff will utilize that to monitor R1's blood glucose. The licensee's Medication and Treatment Orders policy dated September 1, 2023, indicated residents who receive medication management services by the licensee will have a current physician prescribed medication or treatment/therapy orders on record.	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40861	A. BUILDING: _____ B. WING _____	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNFLOWER HOMES HEALTH LLC	901 REDWELL LANE APPLE VALLEY, MN 55124

(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
01970	Continued From page 43 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents, staff, and any visitors of the facility. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The finding include: On July 28, 2025, at approximately 10:00 a.m.	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40861	A. BUILDING: _____ B. WING _____	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNFLOWER HOMES HEALTH LLC	901 REDWELL LANE APPLE VALLEY, MN 55124

(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
03090	Continued From page 44 upon arriving at the establishment, the surveyor did not observe the required posting for electronic monitoring devices outside the front entrance, or just inside the front entrance, as required. On July 29, 2025, at 8:13 a.m., clinical nurse supervisor (CNS)-B stated she thought the electronic monitoring posting was only if the licensee used cameras, which they did not. The licensee's Electronic Monitoring policy dated June 1, 2024, indicated signs are installed at each facility entrance accessible to visitors that state: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Sunflower Homes Health LLC
901 Redwell Lane
Apple Valley, MN 55124
Dakota County
Parcel:

Phone:

License Info

License: HFID 40861

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

Inspection Info

Report Number: F1004251088
Inspection Type: Full - Single
Date: 7/28/2025 Time: 12:00:00 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

! **New Order: 3-300B Protection from Contamination: cross-contamination, eggs**
3-302.11A(1) *Priority Level: Priority 1 CFP#: 15*
MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.
COMMENT: **RAW SHELL EGGS FOUND ON THE TOP SHELF OF THE REFRIGERATOR, OVER READY-TO-EAT ITEMS AND PRODUCE. ENSURE RAW ANIMAL FOODS ARE STORED BELOW AND SEPARATE FROM READY-TO-EAT ITEMS. *EGGS MOVED TO THE BOTTOM DRAWER DURING INSPECTION.**
Comply By: 7/28/2025 Originally Issued On: 7/28/2025

Food & Beverage General Comment

INSPECTION WAS CONDUCTED BY MOLLY DOUGHERTY (FPLS) IN CONJUNCTION WITH A HEALTH REGULATIONS DIVISION (HRD) SURVEY CONDUCTED BY KASSIE MARKING.

DISCUSSED:
-EMPLOYEE ILLNESS POLICY AND LOG
-HANDWASHING
-SANITIZER USE
-CLEANING/SANITIZING FOOD CONTACT SURFACES AND UTENSILS
-HIGH TEMPERATURE SANITIZING DISH MACHINE TEMPERATURE VERIFICATION
-DATE MARKING PROCEDURES
-THERMOMETER USE AND CALIBRATION
-SERVING A HIGHLY SUSCEPTIBLE POPULATION (NO RAW/UNDERCOOKED ANIMAL FOODS, NO UNPASTEURIZED JUICE, MILK, ETC)
-VOMIT/FECAL INCIDENT CLEAN UP PROCEDURES
-FOOD SOURCE
-FOOD SERVICE PROCEDURES (SAME DAY SERVICE)
-PEST CONTROL
-PHYSICAL FACILITIES AND MAINTENANCE

*REPORT WAS DISCUSSED WITH THE PERSON IN CHARGE ON SITE, HASSAN, AND WITH THE NURSE EVALUATOR, KASSIE.

*FLOORS ARE SEALED HARDWOOD, WALLS AND CEILING ARE SMOOTH PAINTED DRYWALL. COUNTERTOPS ARE LAMINATE AND CABINETS ARE VARNISHED WOOD WITH HALLOW BASE. 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.

*KITCHEN HAS A 2-BASIN SINK. ONE BASIN IS DESIGNATED AS THE HANDWASHING SINK. THIS BASIN MAY ONLY BE USED FOR HANDWASHING PURPOSES.

*IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE RESIDENT. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1004251088 from 7/28/2025

Molly Dougherty

Hassan Moalim

Molly Dougherty,
Public Health Sanitarian 3
651-201-3978
molly.dougherty@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

Sunflower Homes Health LLC
Apple Valley
County/Group: Dakota County

Inspection Info

Report Number: F1004251088
Inspection Type: Full
Date: 7/28/2025
Time: 12:00:00 PM

Equipment Temperature: Product/Item/Unit: ambient temperature**; Temperature Process:** Cold-Holding
Location: kitchen refrigerator at <37 Degrees F.
Comment:
Violation Issued?: No

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

Food Temperature: Product/Item/Unit: prepared vegetable dish**; Temperature Process:** Cold-Holding
Location: kitchen refrigerator at 37 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

Sunflower Homes Health LLC
Apple Valley
County/Group: Dakota County

Inspection Info

Report Number: F1004251088
Inspection Type: Full
Date: 7/28/2025
Time: 12:00:00 PM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 168 Degrees F.
Comment:
Violation Issued?: No