Electronically Delivered

April 3, 2025

Licensee
Sunset Homes Assisted Living
11237 11th Avenue Nw
Oronoco, MN 55960

RE: Project Number(s) SL27053016

Dear Licensee:

On March 4, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the December 18, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

JMD

Electronically Delivered

February 5, 2025

Licensee
Sunset Homes Assisted Living
11237 11th Avenue Northwest
Oronoco, MN 55960

RE: Project Number(s) SL27053016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 18, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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. 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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27053	A. BUILDING: _____ B. WING _____	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOMES ASSISTED LIVING	11237 11TH AVENUE NW ORONOCO, MN 55960

(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 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: SL27053016 On December 16, 2024, through December 18, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 6 resident(s); 6 receiving services under the Assisted Living Facility license. 2310: An immediate order was issued on December 16, 2024, at a level 3, Isolated (G). The licensee took action; however, the scope and level remain at G.	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.	

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0 110	Continued From page 1	0 110		
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the client/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 the potential to affect a large portion or all the residents). The findings include: The Board of Executives for Long-Term Services and Support (BELTSS) website was reviewed and indicated LALD-A held a current assisted living director license (issued June 17, 2021; with an expiration date of October 31, 2025). The website indicted the Director of Record expired on October 31, 2022. On December 16, 2024, at 11:10 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated he was aware of the	0 110		

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0 110	Continued From page 2 requirements and was the director of record. The LALD/RN-A stated it must be a mistake and would call BELTSS. The licensee's Licensed Director Availability and Communication policy dated September 22, 2023, indicated the licensed assisted living director on record (LALD) will be available to communicated daily with residents, family, and staff. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (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;	0 480		

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0 480	Continued From page 3 (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, 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	0 480		

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0 480	Continued From page 4 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 December 16, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by:	0 640		

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0 640	Continued From page 5 Based on observation and interview, the licensee failed to support protection and safety by not posting information the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of residents). The findings include: On December 16, 2024, at 11:30 a.m. during the facility tour, 911 emergency number was not observed to be posted in common areas and near telephones provided by the assisted living facility. Registered nurse (RN)-B stated they have the sign posted at other buildings and it used to be hanging above the phone, so someone must have taken it down. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation:	0 650		

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0 650	Continued From page 6 (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one employee (unlicensed personnel (ULP)-D)'s records included the required content. 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: ULP-D was hired on June 20, 2017, to provide	0 650		

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0 650	Continued From page 7 direct care under the licensee's assisted living license. On December 17, 2024, at 8:45 a.m., ULP-D was observed completing a dressing change for R2. ULP-D's employee file lacked a job description. On December 17, 2024, at 12:00 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated he was aware of the requirement and thought it was in the record. The licensee's Personnel Records policy dated September 22, 2023, indicated the personal record for each person will include a current job description. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (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	0 680		

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0 680	Continued From page 8 (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's EP plan included an undated, hazard risk assessment. The EP plan lacked the following items: - Maintain and annual EP updates - policies and procedures for volunteers - conduct exercises to test EP at least twice per	0 680		

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0 680	Continued From page 9 year On December 17, 2024, at 2:00 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated he has put a lot of work on his EP plan but was unaware of the requirement for EP testing. The licensee's Emergency and Disaster Preparedness policy dated September 20, 2023, indicated the licensee's emergency plan includes all required elements of appendix Z. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors.	0 800		

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0 800	Continued From page 10 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 17, 2024, at 2:05 p.m., the surveyor toured the facility with licensed assisted living director/registered nurse (LALD/RN)-A. During the tour, the surveyor observed the following: 1. In occupied resident room 5, a space heater was plugged into a power strip. In occupied resident room 2, an extension cord was used to supply power. Improper use of power strips and extension cords creates a fire hazard. 2. The storm door for the side exit door was soiled and had an accumulation of moisture. One of the exterior steps for this exit door was cracked. 3. In resident rooms 1 and 7, the bifold closet doors were off the track. In resident room 1, the knob was missing from one side of the bifold closet door. 4. In resident room 3, the egress window was obstructed by the storage of personal items in front of the window. The improper placement of furniture and personal items could delay exiting in the event of an emergency. 5. Light fixture covers were missing in resident rooms 3 and 4. 6. Light fixture covers were missing in the two resident bathrooms located near resident rooms 3 and 4. A drawer knob was missing from one of	0 800		

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0 800	Continued From page 11 the bathroom sink vanities, making it difficult to open. 7. In resident room 4, there was a hole in the wall behind the bed. 8. In resident room 1, the window was soiled and had an accumulation of moisture. 9. In the basement, a discharge pipe was not attached to the hot water heater temperature and pressure relief valve. Discharge pipes must terminate within 18" of the floor. 10. Tiles were missing along the edge of one step in the link. 11. On the exterior of the facility, one side of the cover was missing from an electrical outlet near the front door. 12. At the designated outdoor smoking area, burnt cigarettes were on the exterior concrete patio and driveway. During the facility tour interview on December 17, 2024, LALD/RN-A stated the disposal container had recently blown over in the wind and the burnt cigarettes had fallen out of the container and onto the ground. LALD/RN-A stated this would be cleaned up right away. During the facility tour interview on December 17, 2024, LALD/RN -A verified the above listed observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping	0 810		

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0 810	Continued From page 12 rooms; (2) staff 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) Staff 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 staff 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 observation, record review, and interview, the licensee failed to clearly identify resident sleeping rooms and provide required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 810		

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0 810	Continued From page 13 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 17, 2024, at 2:05 p.m., the surveyor toured the facility with licensed assisted living director/registered nurse (LALD/RN)-A. During the tour, the surveyor observed a room identifier was not posted on or at the door for resident sleeping room 2. The other resident sleeping rooms were identified using small pieces of masking tape on the doors, which were difficult to read. Room identifiers installed at the resident sleeping room doors must be legible and sized appropriately to provide efficient communication for exiting in the event of a fire or similar emergency. During the facility tour interview on December 17, 2024, LALD/RN-A verified the above listed observations and stated new room identifiers would be installed. On December 17, 2024, LALD/RN-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year evident by the lack of training documentation. During an interview on December 17, 2024, at 4:15 p.m., LALD/RN-A stated residents were trained during fire drills. LALD/RN-A explained that when residents participated in fire drills their names were recorded on the drill logs. LALD/RN-A verified no additional resident training had been	0 810		

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0 810	Continued From page 14 completed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01420 SS=D	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date in which the individual began working for the licensee for one of one unlicensed personnel (ULP-D). 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	01420		

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01420	Continued From page 15 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: ULP-D was hired on June 20, 2017, to provide direct care under the licensee's assisted living license. On December 17, 2024, at 8:45 a.m., the surveyor observed ULP-D complete a dressing change for R2. ULP-D's employee records lacked evidence direct supervision of ULP-D performing delegated tasks was provided within 30 calendar days after the date on which ULP-D began working for the facility and first performed the delegated tasks for residents. On December 16, 2024, at 9:30 a.m. during the entrance conference, licensed assisted living director/registered nurse (LALD/RN)-A and registered nurse (RN)-B stated the staff are trained by the nurse, and the licensee also uses Educare (an online training program) for their ULP training. On December 17, 2024, at 12:58 p.m., LALD/RN-A and RN-B stated they were aware of the requirements and thought training was completed. The licensee's Delegation of Nursing Tasks policy January 5, 2022, indicated the RN will verify the ULP is trained and competent and is instructed in the proper methods to perform the task with	01420		

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01420	Continued From page 16 respect to the specific resident. The RN or other appropriately licensed staff will document any ULP training and/or competencies. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01420		
01470 SS=D	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 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	01470		

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01470	Continued From page 17 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 access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one employee (unlicensed personnel (ULP)-D completed orientation to assisted living facility licensing requirements and regulations. This practice resulted in a level two violation (a	01470		

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01470	Continued From page 18 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-D was hired on June 20, 2017, to provide direct care under the licensee's assisted living license. On December 17, 2024, at 8:45 a.m., the surveyor observed ULP-D complete a dressing change for R2. ULP-D's employee records lacked the following required orientation content: - an overview of the Assisted Living statutes. - handling of resident complaints, reporting of complaints, where to report - consumer advocacy services - review of the types of assisted living services as indicated on the Uniform Disclosure of Assisted Living Services and Amenities and providers scope of licensure. On December 17, 2024, at 12:58 p.m., licensed assisted living director/registered nurse (LALD/RN)-A and registered nurse (RN)-B stated they were aware of the requirements and thought training was completed. The licensee's Assisted Living Orientation- ULP Staff Policy dated September 20, 2023, indicated newly hired unlicensed personnel will receive orientation and training on topics required by Minnesota statutes and rules for assisted living	01470		

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01470	Continued From page 19 organizations. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and	01500		

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01500	Continued From page 20 procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the 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 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 annual training included all required topics for each 12 months of employment for one of one employee unlicensed personnel (ULP)-D. 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	01500		

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01500	Continued From page 21 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: ULP-D was hired on June 20, 2017, to provide direct care under the licensee's assisted living license. On December 17, 2024, at 8:45 a.m., the surveyor observed ULP-D complete a dressing change for R2. ULP-D's employee record contained evidence of four hours of annual training in the following areas for 2024: -Emergency Preparedness -Medication and Treatment Catheter -Medication and Treatment CPAP ULP-D's employee training records lacked evidence ULP-E had successfully completed annual training as required in the following areas: - training on reporting of maltreatment of vulnerable adults. - review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights. - review of infection control techniques. - Effective approaches to problem solve working with a resident's challenging behaviors. - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.	01500		

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01500	Continued From page 22 On December 17, 2024, at 12:58 p.m., licensed assisted living director/registered nurse (LALD/RN)-A and registered nurse (RN)-B stated they were aware of the requirements and thought training was completed. The licensee's Assisted Living Annual Training policy dated September 20, 2023, indicated all assisted living employees will complete annual education on the following topics: - reporting maltreatment of vulnerable adults - assisted living bill of rights - staff responsibility related to the protection of the bill of rights - infection control - working with challenging behaviors - person-centered care - emergency and disaster training - review of policies and procedures relating to assisted living services No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed	01530		

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01530	Continued From page 23 at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one employee (unlicensed personnel (ULP)-D) received the required amount of dementia care 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: ULP-D was hired on June 20, 2017, to provide direct care under the licensee's comprehensive home care license, before transitioning to the	01530		

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01530	Continued From page 24 assisted living license on August 1, 2021. On December 17, 2024, at 8:45 a.m., the surveyor observed ULP-D complete a dressing change for R2. ULP-D's employee record contained evidence of the following dementia training: February 5 and 6, 2022, 3.75 hours of completed dementia training. March 29, 2023, 1.25 hours of completed dementia training. June 30, 2023, 2.5 hours of completed dementia training. No dementia training was completed in 2024. ULP-D's employee records did not contain documentation ULP-D completed eight hours of dementia training within 160 hours of ULP-D's start date and at least two hours of annual dementia training. On December 17, 2024, at 12:58 p.m., licensed assisted living director/registered nurse (LALD/RN)-A and RN-B stated they were aware of the requirements and thought training was completed. The licensee's Dementia Training and Disclosure policy dated September 22, 2023, indicated all direct-care staff will have at least 8 hours of initial training on dementia within 120 working hours of the employment start date and at least two hours of training related to dementia for each twelve (12) months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		

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SUNSET HOMES ASSISTED LIVING	11237 11TH AVENUE NW ORONOCO, MN 55960

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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 one of one unlicensed personnel (ULP-D) was trained and competency tested prior to a registered nurse (RN) delegating eye drop medication. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-D was hired on June 20, 2017, to provide direct care under the licensee's comprehensive home care license before transitioning to an assisted living license on August 1, 2021.	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27053	A. BUILDING: _____ B. WING _____	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOMES ASSISTED LIVING	11237 11TH AVENUE NW ORONOCO, MN 55960

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01750	Continued From page 26 On December 17, 2024, at 11:52 a.m., the surveyor observed ULP-D appropriately administer two eye drops into R4's right eye: prednisolone 1 drop, waited five minutes and then moxifloxin 1 drop. ULP-D's employee record lacked evidence the RN deemed ULP-D competent to administer eye drops. On December 17, 2024, at 12:00 p.m., licensed assisted living director/registered nurse (LALD/RN)-A and RN-B stated they were aware of the process and thought training was completed, but they could not find the documentation in ULP-D's employee record. LALD/RN-A stated he would provide the documents if he could find them. ULP-D indicated completing orientation with the RN. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated January 5, 2022, indicated unlicensed personnel that will provide assistance with medication, treatment and therapy administration will be trained and competency tested by the RN. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01750		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27053	A. BUILDING: _____ B. WING _____	12/18/2024

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02310	Continued From page 27 service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure care and services were provided according to acceptable health care and medical or nursing standards for one of one resident (R2) with bedrails. This resulted in an immediate correction order on December 16, 2024. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at 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: On December 16, 2024, at 11:10 a.m., unlicensed personnel (ULP)-C was observed assisting R2. R2 had a hospital bed with a trapeze and head of bed in the up position and a right sided bedrail in the up position. R2 began receiving services on January 22, 2019, with diagnoses of morbid obesity and head injury. R2's comprehensive assessment dated September 2, 2024, indicated R2 was independent with bed mobility. The assessment failed to identify a bed rail was in use.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27053	A. BUILDING: _____ B. WING _____	12/18/2024

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02310	Continued From page 28 R2's comprehensive assessment dated June 4, 2024, indicated R2 indicated resident had a bariatric bed with a trapeze for repositioning. And that the bed safety zone assessment was not applicable, because either resident had no bed rails in use or had portable bed rails installed on a consumer bed. R2's service plan dated November 21, 2023, indicated R2 received services to include medication administration, dressing, and bathing. R2's record lacked: -a bed rail assessment; -measurements of zones of entrapment; and -documentation of risk verses benefits discussion. On December 16, 2024, at 11:45 a.m., ULP-C stated R2 used the bed rail in the up position at night to move in bed and put it down during the day. ULP-C stated R2 can put the bed rail up and down independently. On December 16, 2024, at 1:30 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated R2 had this bed for over one year and they were unaware it had bed rails because R2 did not need them and that it was an error that they are on the bed. LALD/RN-A stated he was aware of the requirements. The Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQs) dated December 13, 2024, indicated the following must be included in the resident record when bed rails were in use: -an assessment was completed; -measurements were completed and documented;	02310		

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02310	Continued From page 29 -the rails were United States Food and Drug Administration (FDA) compliant; and -the risk vs. benefits were discussed and documented with the resident/responsible party. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The licensee took action to mitigate the risk on December 16, 2024; however, the citation remains at a G.	02310		

Minnesota Department of Health
Food, Pools, Lodging
3425 40th Ave NW
Rochester
507-206-2721

Type: Full
Date: *12/16/24*
Time: 09:54:00
Report: 8074241241

Food and Beverage Establishment Inspection Report

Location:
Sunset Homes Assisted Living
11237 11th Avenue NW
Oronoco, MN55960
Olmsted County, 55

Establishment Info:
ID #: 0039905
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/21

Operator:

Phone #: 5073674438
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.

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

Cabinet by handles and bottom have build up, started cleaning during inspection.
Comply By: 12/16/24

Surface and Equipment Sanitizers

Hot Water: = at 180 Degrees Fahrenheit
Location: internal dish strip records
Violation Issued: No

Quaternary Ammonia: = 200ppm at Degrees Fahrenheit
Location: spary bottle
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: milk
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: milk
Violation Issued: No

Type: Full
Date: *12/16/24*
Time: 09:54:00
Report: 8074241241
Sunset Homes Assisted Living

Food and Beverage Establishment Inspection Report

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

Establishment Info: jane_atuti@yahoo.com

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 8074241241 of 12/16/24.

Certified Food Protection Manager: Jane Moraa Nyamwaro

Certification Number: FM111915 Expires: 07/16/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: _____
Andrea Kieffer

Rochester District Office