Electronically Delivered

July 17, 2023

Licensee
Sunrise Of Minnetonka
18605 Old Excelsior Boulevard
Minnetonka, MN 55345

RE: Project Number(s) SL24010015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 27, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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. The MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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

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

The correction order documentation should include the following:

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

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

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 651-281-9796

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24010	A. BUILDING: _____ B. WING _____	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF MINNETONKA	18605 OLD EXCELSIOR BOULEVARD MINNETONKA, MN 55345

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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: SL24010015 On June 26, 2023, through June 27, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were forty-nine (49) active residents receiving services under the Assisted Living with Dementia Care 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 License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

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0 470	Continued From page 1 (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the staffing plan was posted for residents, staff, and visitors to review as required. 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, but was not likely to cause serious injury, impairment, or death), and	0 470		

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0 470	Continued From page 2 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 observation on June 26, 2023, at 11:30 a.m., the surveyor did not observe a posted staff schedule in any area of the facility developed by the clinical nurse supervisor to: - include direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked, - identify the direct-care staff member's resident assignments or work location, and - be posted after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location in each building. On June 26, 2023, at 2:10 p.m., licensed assisted living director (LALD)-C informed the surveyor that it was not the licensee's policy to post a staffing schedule and was not aware that this was a requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules,	0 480		

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0 480	Continued From page 3 chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all residents in the Assisted Living with Dementia Care facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated June 28, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure,	0 650		

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0 650	Continued From page 4 registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure current employee records were maintained to include all required content for one of two employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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-B was hired December 14, 2014, to provide direct care and services to the licensee's	0 650		

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0 650	Continued From page 5 residents. ULP-B's employee file lacked an annual performance employee review. On June 26, 2023, at approximately 2:40 p.m., director of nursing (DON)-A stated she believed ULP-B would have had a current annual performance evaluation completed and the record would be located in ULP-B's employee file. DON-A stated she made it a priority to be current on employee performance reviews. The licensee's Employee Records policy dated August 1, 2021, indicated employee records would include evidence of professional licensure and a current signed job description. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) 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 6 (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 observation, interview, and record review, the licensee failed to develop an emergency disaster plan (EDP) containing all the requirements outlined in Appendix Z and posted prominently. 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 the residents). The findings include: During the entrance conference on June 26, 2023, at 10:15 a.m., licensed assisted living director (LALD)-C stated the licensee did have an emergency disaster plan (EDP) binder. During a tour of the licensee's establishment on June 26, 2023, at 11:00 a.m., surveyor did not	0 680		

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0 680	Continued From page 7 observe an EDP posted anywhere for staff, visitors, employees, or volunteers to view. The licensee's EDP documentation lacked the following components: - post an emergency disaster plan prominently - program patient population -subsistence needs for staff and residents -tracking staff and residents - phone tree lacked phone numbers and names -volunteer policies and procedures -roles under a waiver declared by Secretary -communication plan -sharing information occupancy needs -family notifications -emergency prep testing requirements - no tests in staff training records During interview on June 26, 2023, at 2:20 p.m., LALD-C stated he was told by licensee's corporate office that they had been working on the EDP and thought the documents LALD-C had were the current EDP plan. No further information was provided. TIME PERIOD TO CORRECT: 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	0 800		

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0 800	Continued From page 8 repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on June 28, 2023, at approximately 11:00 a.m. with licensed assisted living director (LALD)-C and senior maintenance coordinator (MD)-E, storage was observed in the marked exit corridor near the main floor commercial kitchen laundry and storage area. Keeping this marked exit corridor clear of storage and obstructions helps ensure the means of egress is available for use by building occupants and emergency responders in the event of an emergency. On the same tour it was observed the light switch was broken in the bathroom of resident room 114. An outlet cover was observed missing in one of the storage closets of the activities room on	0 800		

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0 800	Continued From page 9 second floor. A light fixture globe cover was observed missing in the second storage closet in the second-floor activities room. Electrical outlets and fixtures are required to be maintained as designed and installed at the time of construction approval. A piece of chair rail was observed missing, which exposed a sharp corner in the corridor near the roof access door. These deficient conditions were visually verified by LALD-C and MD-E accompanying on the tour. 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 rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be	0 810		

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0 810	Continued From page 10 readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to maintain the facility's fire safety and evacuation plan with required elements. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review of available documentation and interview were conducted on June 28, 2023, at approximately 10:15 a.m. of documents provided by licensed assisted living director (LALD)-C and senior maintenance coordinator (MD)-E on the fire safety and evacuation plan, fire safety and	0 810		

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0 810	Continued From page 11 evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the facility provided a fire safety and evacuation floor plan, but the floor plan map did not include location and numbers of resident rooms. Record review of the available documentation indicated that the facility failed to provide unique and unusual needs for individual resident evacuation in the event of a fire or similar emergency. The resident individual unique and unusual needs for evacuation is valuable information for facility staff use in the event of an evacuation and for use to communicate these individual evacuation needs to emergency responders. All deficiencies were verified by LALD-C and MD-E during the interview at approximately 11:00 a.m. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and	02040		

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02040	Continued From page 12 (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review of available documentation and interview were conducted June 28, 2023, at approximately 10:30 a.m. with licensed assisted living director (LALD)-C and senior maintenance coordinator (MD)-E on the hazard vulnerability assessment for the physical environment of the facility. Record review of the available documentation indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the specific property. This deficient condition was verified by LALD-C and MD-E during the interview at approximately 12:45 p.m.	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24010	A. BUILDING: _____ B. WING _____	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF MINNETONKA	18605 OLD EXCELSIOR BOULEVARD MINNETONKA, MN 55345

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02040	Continued From page 13 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		
02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including: (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to designate a qualified person (director of nursing (DON)-A) to oversee staff training in the care of individuals with dementia. 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 the residents). The findings include: During the entrance conference on June 26, 2023, at approximately 10:30 a.m., DON-A stated	02140		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24010	A. BUILDING: _____ B. WING _____	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF MINNETONKA	18605 OLD EXCELSIOR BOULEVARD MINNETONKA, MN 55345

(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
02140	Continued From page 14 she oversaw training staff in the care of individuals with dementia. DON-A had a hire date of October 28, 2019, and provided supervision and training to unlicensed personnel (ULP) in the licensee's assisted living with dementia care establishment. DON-A's employee record lacked documentation of completion of an approved competency and knowledge test as required for supervising staff in an assisted living facility with dementia care. On June 27, 2023, at approximately 10:30 a.m., DON-A stated she had not completed an approved competency and knowledge test required for supervising staff in an assisted living facility with dementia care. DON-A stated there was another registered nurse (RN) employed by the licensee that was in the process of completing an approved competency and knowledge test in dementia but at the time there was not a supervising staff member that had completed this requirement. During interview on June 27, 2023, at 11:35 a.m., licensed assisted living director (LALD)-C confirmed there were no other staff members hired by the licensee that had completed an approved competency and knowledge test required for supervising staff in an assisted living facility with dementia care. No further information was provided. TIME PERIOD TO CORRECT: Twenty-One (21) days	02140		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24010	A. BUILDING: _____ B. WING _____	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF MINNETONKA	18605 OLD EXCELSIOR BOULEVARD MINNETONKA, MN 55345

(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
02320	Continued From page 15	02320		
02320 SS=F	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure unlicensed personnel (ULP) followed appropriate medication administration procedures for one of one employee (ULP)-B) observed during medication administration. 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: During medication administration observation on June 26, 2023, at 11:53 a.m., ULP-B stood next to R4 and proceeded to check R4's blood glucose level using a blood glucose meter. ULP-B then proceeded to take a handwritten sheet of paper out of R4's blood glucose meter holder and reviewed it. When asked, ULP-B explained R4's sliding scale insulin dosing was written on the paper. ULP-B stated she did this because she did	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24010	A. BUILDING: _____ B. WING _____	06/27/2023

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02320	Continued From page 16 not want to bring the computer into R4's room as it was attached to the medication cart. ULP-B stated she had reviewed R4's electronic medication administration record (EMAR) before she left the medication room. ULP-B stated the nursing staff were responsible for writing the insulin sliding scale dosing on the paper. R4's EMAR dated June 26, 2023, indicated ULP-B prepared the following medications to administer to R4 at 12:00 p.m.: Novolog insulin; 5 units per sliding scale dosing. On June 26, 2023, at 1:10 p.m., director of nursing (DON)-A and the surveyor discussed the observation regarding the setup process and administration of medications to R4. DON-A stated, "I was unaware of that. No, they are not taught to do that." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

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

Type: Full
Date: *06/28/23*
Time: 08:30:00
Report: 8041231183

Food and Beverage Establishment Inspection Report

Location:
Sunrise Of Minnetonka
18605 Old Excelsior Boulevard
Minnetonka, MN55345
Hennepin County, 27

Establishment Info:
ID #: 0037647
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9524749155
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.

4-500 Equipment Maintenance and Operation

4-501.114C1 ***** Priority 1 *****

MN Rule 4626.0805C1 Provide and maintain an approved chlorine chemical sanitizer solution that has a minimum concentration of 50 ppm and a minimum temperature of 75 degrees F (24 degrees C) for water with a pH of 8 or less or a minimum temperature of 100 degrees F (38 degrees C) for water with a pH of 8.1 to 10.

DISH MACHINE IN MEMORY CARE DISPENSING 0 PPM CHLORINE SANITIZER SOLUTION. INSPECTOR ATTEMPTED TO PRIME MACHINE. ESTABLISHMENT WILL CONTACT ECOLAB TO SERVICE. DISCONTINUE USE UNTIL MACHINE IS DISPENSING AT LEAST 50 PPM CHLORINE.

Comply By: 06/28/23

4-600 Cleaning Equipment and Utensils

4-601.11A ***** Priority 2 *****

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

FOOD DEBRIS FOUND ON THE BACK OF THE BLADE ON THE MEAT SLICER. SLICER WILL BE TAKEN APART AND CLEANED AND SANITIZED THOROUGHLY.

Comply By: 06/28/23

4-200 Equipment Design and Construction

4-202.16

MN Rule 4626.0540 Provide non-food contact surfaces that are free of unnecessary ledges, projections and crevices and are designed and constructed to allow easy cleaning.

A SECTION OF THE CABINET BY THE RINSE SINK IN MEMORY CARE IS IN POOR REPAIR.

Comply By: 07/28/23

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.

1. BUILD-UP OF FOOD DEBRIS ON THE TOP UNDERSIDE OF THE LARGE MIXER. 2. THE BOTTOM OF THE REACH-IN FREEZER IN MEMORY CARE HAS A BUILD-UP OF ICE AND FOOD DEBRIS.

Comply By: 07/03/23

Surface and Equipment Sanitizers

Acid: = 700 ppm at Degrees Fahrenheit
Location: 3 comp. sink
Violation Issued: No

Acid: = 700 ppm at Degrees Fahrenheit
Location: sani bucket- prep
Violation Issued: No

Utensil Surface Temp.: = at 165 Degrees Fahrenheit
Location: kitchen dish machine
Violation Issued: No

Chlorine: = 0 ppm at Degrees Fahrenheit
Location: memory care dish machine
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: cold table: turkey
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: cold table: sliced tomato
Violation Issued: No

Process/Item: Hot Holding
Temperature: 172 Degrees Fahrenheit - Location: steam table: scrambled egg
Violation Issued: No

Process/Item: Cold Holding
Temperature: 36 Degrees Fahrenheit - Location: upright cooler: milk
Violation Issued: No

Process/Item: Thawing
Temperature: 31 Degrees Fahrenheit - Location: walk-in cooler: sausage link
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: walk-in cooler: turkey
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: walk-in cooler: ham
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: memory care reach-in: ambient air temp.
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: memory care- upright cooler: salad
Violation Issued: No

Process/Item: Cold Holding
Temperature: 35 Degrees Fahrenheit - Location: bistro reach-in: ambient air temp.
Violation Issued: No

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

Inspection was completed with the Executive Director, Tommaso Cammarano. Elyse Jones was the lead Health Regulation Division Nurse Evaluator.

This establishment has a commercial kitchen on the main floor and a serving kitchen in memory care. There is also a bistro area on near the entry that has coffee, water and cookies available for residents/guests.

Discussed the following:
-Employee illness policy and logging requirements
-Handwashing
-Glove-use and bare hand contact
-Proper food storage
-Date marking
-Vomit clean-up procedures
-Restrictions concerning serving a highly susceptible population

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 8041231183 of 06/28/23.

Certified Food Protection Manager: Greg Latzke

Certification Number: fm80479 Expires: 05/17/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Tommaso Cammarano
Executive Director

Signed: Sarah Conboy
Sarah Conboy
Public Health Sanitarian III
651-201-3984
sarah.conboy@state.mn.us