Electronically Delivered

April 14, 2025

Licensee
Sunset Homes Assisted Living
3686 Kenosha Drive Northwest
Rochester, MN 55902

RE: Project Number(s) SL30659016

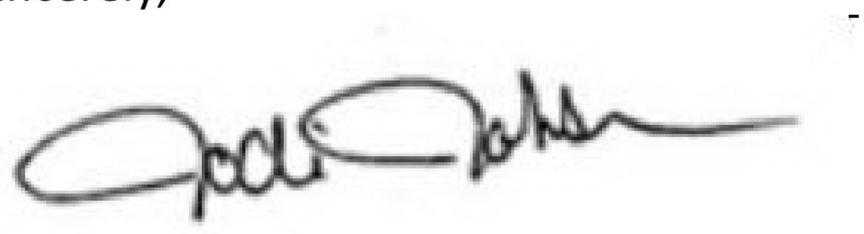
Dear Licensee:

On March 18, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the January 15, 2025, 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

HHH

Electronically Delivered

February 20, 2025

Licensee
Sunset Homes Assisted Living
3686 Kenosha Drive Northwest
Rochester, MN 55902

RE: Project Number(s) SL30659016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 15, 2025, 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:

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30659	A. BUILDING: _____ B. WING _____	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOMES ASSISTED LIVING	3686 KENOSHA DRIVE NW ROCHESTER, MN 55902

(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: SL30659016-0 On January 13, 2025, through January 15, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were four residents; four receiving services under the Assisted Living Facility license. 1290: An immediate order was issued on January 14, 2025, at a level 3/Widespread (I) The licensee took action on January 14, 2025; however, the scope and level remain at I.	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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0 630	Continued From page 1	0 630		
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 one of 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 R1 began receiving assisted living services on August 1, 2021.	0 630		

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0 630	Continued From page 2 R1's diagnoses included type two diabetes and depression. R1's Service Plan dated January 6, 2025, indicated he received the services of medication administration, behavior management, blood sugar monitoring, wound care management, and bathing reminders. On January 13, 2025, at 1:50 p.m., unlicensed personnel (ULP)-C administered R1's afternoon medications and observed R1 to check his blood sugar with his Dexcom device (an electronic sensor device to read continuous blood sugar levels). R1's IAPP dated December 29, 2024, indicated R1 was not at risk to be abused. R1's IAPP also indicated R1 had the following vulnerabilities: -difficulty with weighing advice, impaired judgement -has selective mutism, difficulty with communication, may not report abuse or neglect. The licensee failed to properly depict R1's vulnerability to abuse by others and failed to implement measures to minimize the risk of abuse to R1. On January 15, 2025, at 9:50 a.m., clinical nurse supervisor (CNS)-B stated, "I thought I answered that question properly as the residents can tell us if they were being abused. The residents are vulnerable adults, and I had not thought about their other vulnerabilities to include neglect, self-abuse/neglect, and financial exploitation." The licensee's Individual Abuse Prevention Plans policy dated January 18, 2024, indicated the Individual Abuse Prevention Plan will include:	0 630		

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0 630	Continued From page 3 a. Individualized review or assessment of the resident's susceptibility to be abused by another individual, including other vulnerable adults b. The resident's risk of abusing other vulnerable adults c. Specific measures to minimize the risk of abuse to that person and other vulnerable adults. d. Measure to minimize the risk of self-abuse, if applicable No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
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. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 800		

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0 800	Continued From page 4 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 January 14, 2025, at 10:35 a.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. The door for the laundry room had been removed. During the facility tour interview, LALD/RN-A stated the laundry room door would be reinstalled. LALD/RN-A stated the door was removed to provide easier access in and out of the room. 2. The light bulbs did not work in the laundry room light fixture. Two light bulbs did not work in the basement bathroom light fixture above the sink vanity. During the facility tour interview, LALD/RN-A stated the bulbs were burnt out and the light fixtures worked properly. LALD/RN-A stated the light bulbs would be replaced. 3. In the dining room, the handle for the sliding patio screen door was taped making it difficult to operate. During the facility tour interview, LALD/RN-A stated residents had damaged the screen door handle and this would be repaired. 4. One area of the concrete sidewalk was in disrepair near the front door. During the facility tour interview, LALD/RN-A verified the above listed observation and stated this would be patched once the weather warmed. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		

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0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) 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 accurately identify	0 810		

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0 810	Continued From page 6 a fire extinguisher location 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 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 January 14, 2025, at 10:35 a.m., the surveyor toured the facility with licensed assisted living director/registered nurse (LALD/RN)-A. During the tour, the surveyor observed a fire extinguisher was not installed in the basement utility room. The posted floor plan labeled a fire extinguisher in this location. The emergency evacuation floor plan must be accurate to provide efficient communication in the event of a fire or similar emergency. During the facility tour interview on January 14, 2025, LALD/RN-A verified the above listed observation and stated a new fire extinguisher would be installed in the utility room as labeled on the floor plan. On January 14, 2025, 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 January 14, 2025, at 12:15 p.m.,	0 810		

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0 810	Continued From page 7 LALD/RN-A stated residents were trained during fire drills. LALD/RN-A verified additional resident training had not been completed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to:	01060		

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01060	Continued From page 8 (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation for one of 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 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: R1 began receiving assisted living services on August 1, 2021. R1's Service Plan dated January 6, 2025, indicated he received the services of medication	01060		

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01060	Continued From page 9 management, blood sugar monitoring, wound care, and bathing reminders. R1's progress notes/ nurse's notes included the following entries: - December 10, 2024, resident woke up this morning and c/o [complaining of] feeling sick and then he threw up and was having fever of 103, BP [blood pressure] 120/80, P [pulse]-130, caregiver called writer to assess. Resident was in agreement to go to the hospital. Resident was taken to the ER [emergency room] by staff at around 9 a.m. Guardian and social worker were updated by phone. Follow up phone call this evening was made and writer talked to nurse who stated resident was admitted for observation due to unresolved fever. -December 16, 2024, resident was readmitted back to facility after 5 [five]-day hospital stay for treatment of a urinary tract infection. Resident was put on amoxicillin TID [three times daily] for 9 [nine] days. R1's [provider name] discharge summary dated December 16, 2024, indicated a hospitalization from December 10, 2024, through December 16, 2024, for septicemia (an infection also affecting the blood stream). R1's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement	01060		

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01060	Continued From page 10 that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R1's records lacked notification to the Office of Ombudsman for Long-Term Care the resident had been relocated and had not returned to the facility within four days. On January 13, 2025, at 12:33 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated R1 had a five-day hospitalization in December, and he had just learned of the requirement to complete an emergency relocation form and notify the ombudsman. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days.	01060		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30659	A. BUILDING: _____ B. WING _____	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOMES ASSISTED LIVING	3686 KENOSHA DRIVE NW ROCHESTER, MN 55902

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01290	Continued From page 11 (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was current, affiliated, and eligible on NETStudy 2.0 (web-based system for submitting background study requests to the Department of Human Services (DHS)) with the assisted living license for four of six employees (ULP-D, ULP-C, ULP-E, ULP-F). This had the potential to affect all residents residing in the facility. This resulted in an immediate correction order issued on January 14, 2025. 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 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: ULP-D ULP-D was hired on April 29, 2014, to provide direct care services under the comprehensive home care license with an agency identification number 26018. ULP-D's employee file included a cleared	01290		

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	30659	A. BUILDING: _____ B. WING _____	01/15/2025

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01290	Continued From page 12 background study dated April 21, 2014, for the comprehensive home care license number 26018. On January 14, 2025, at 8:05 a.m., ULP-D was observed to administer medications to R2. ULP-D was observed to provide direct care services without direct supervision. On January 14, 2025, at 9:30 a.m., licensed assisted living director/registered nurse (LALD/RN)-A provided the surveyor with a NETStudy 2.0 roster printed on January 14, 2025. LALD/RN-A stated the NETStudy roster included all employees hired between his three licensed facilities. LALD/RN-A then highlighted three employees (ULP-C, ULP-E, and ULP-F) on the NETStudy roster and stated they were the employees who worked at this facility (HFID 30659). LALD/RN-A stated he was unable to find ULP-D's name or background clearance on the NETStudy roster and thought it was due to her being an employee for over 10 years and further stated, he understood ULP-D's background study from that time was "batched" differently than employees hired more recently. Further review of the NETStudy website indicated no evidence of ULP-D's background clearance. On January 14, 2025, at 2:30 p.m., LALD/RN-A stated ULP-D's background clearance had shown up on previous NETStudy rosters he had printed and reviewed; however, in about 2019, he noticed ULP-D's name no longer appeared. He recalled some notification about needing to archive background studies but didn't know what to do and took no further action. The licensee failed to ensure ULP-D had a	01290		

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	30659	A. BUILDING: _____ B. WING _____	01/15/2025

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01290	Continued From page 13 current and eligible background study. ULP-C ULP-C had a hire date of December 6, 2024, to provide direct care services for the licensee's residents. On January 13, 2025, at 1:50 p.m., ULP-C was observed to administer medications to R1. ULP-C's employee file included a background study dated December 4, 2024, and was affiliated with comprehensive home care license HFID 26018. ULP-E ULP-E had a hire date of March 10, 2023, to provide direct care services for the licensee's residents. ULP-E's employee file included a background study dated February 8, 2023, and was affiliated with comprehensive home care license HFID 26018. ULP-F ULP-F had a hire date of December 17, 2016, to provide direct care services for the licensee's residents. ULP-F's employee file included a background study dated November 29, 2016, and was affiliated with comprehensive home care license HFID 26018. On January 14, 2025, at 1:15 p.m., LALD/RN-A stated the licensee's previous comprehensive home care license HFID 26018 was still enabled	01290		

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01290	Continued From page 14 in the NETStudy system and he was still affiliating employees with that HFID. On January 14, 2025, at 2:25 p.m., LALD/RN-A stated ULP-C, ULP-E, and ULP-F provided direct care to the licensee's residents and had worked without direct supervision. The licensee failed to ensure ULP-C, ULP-E, and ULP-F's background studies were affiliated with the facility's assisted living HFID 30659. The licensee's Background checks policy dated September 20, 2023, indicated all employees, as well as contractors, and regularly scheduled volunteers of the facility with direct resident contact will undergo a background study through DHS. Only those with satisfactory results will continue to work with the facility and it's residents. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The licensee took action on January 14, 2025; however, the scope and level remain at I.	01290		
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	01500		

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01500	Continued From page 15 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 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	01500		

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	30659	A. BUILDING: _____ B. WING _____	01/15/2025

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01500	Continued From page 16 (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 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 April 29, 2014, to provide direct care services for the licensee. ULP-D's record included her Educare (the licensee's online training system) transcript printed January 14, 2025. The training transcript indicated the last annual training was completed on June 30, 2023. ULP-D's employee file lacked evidence she completed the following required annual training: -reporting maltreatment of vulnerable adults or minors (last taken June 30, 2023);	01500		

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	30659	A. BUILDING: _____ B. WING _____	01/15/2025

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01500	Continued From page 17 -infection control techniques (last taken February 27, 2020); and -principles of person-centered planning/service delivery (last taken June 30, 2023). On January 15, 2025, at 10:15 a.m., clinical nurse supervisor (CNS)-B stated ULP-D had been assigned the above listed classes/training but had not yet completed the training. The licensee's Assisted Living Training policy dated September 20, 2023, indicated all assisted living employees will complete annual education on the following topics: a. Reporting of maltreatment of vulnerable adults under section 626.55 7 d. Infection control techniques used in the home and implementation of infection control standards including i. Hand washing ii. Need for and use of protective gloves, gowns, and masks iii. Appropriate disposal of contaminated materials and equipment such as dressings, needles, syringes, and razor blades iv. Disinfecting reusable equipment v. Disinfecting environmental surfaces vi. Reporting communicable diseases h. Principles of person-centered planning and service delivery i. How person-centered planning and service delivery applies to direct support services provided by staff No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		

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01620	Continued From page 18	01620		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a timely comprehensive assessment for a change in condition for one of 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	01620		

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01620	Continued From page 19 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: R1 was admitted to the facility under the Assisted Living Facility (ALF) license on August 1, 2021, with diagnoses including type 2 diabetes, depression, and hypertension. R1's Service Plan dated January 9, 2025, indicated he received services to include medication administration, blood sugar management, and bathing reminders. R1's progress notes/ nurse's notes included the following entries: - December 10, 2024, resident woke up this morning and c/o [complaining of] feeling sick and then he threw up and was having fever of 103, BP [blood pressure] 120/80, P [pulse]-130, caregiver called writer to assess. Resident was in agreement to go to the hospital. Resident was taken to the ER [emergency room] by staff at around 9 a.m. Guardian and social worker were updated by phone. Follow up phone call this evening was made and writer talked to nurse who stated resident was admitted for observation due to unresolved fever. -December 16, 2024, resident was readmitted back to facility after 5 [five]-day hospital stay for treatment of a urinary tract infection. Resident was put on amoxicillin TID [three times daily] for 9 [nine] days. R1's [provider name] discharge summary dated December 16, 2024, indicated a hospitalization	01620		

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	30659	A. BUILDING: _____ B. WING _____	01/15/2025

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01620	Continued From page 20 from December 10, 2024, through December 16, 2024, for septicemia (an infection also affecting the blood stream). On January 13, 2025, at 2:00 p.m., the surveyor requested all registered nurse (RN) assessments completed in the past six months. The following assessments were provided: -September 13, 2024, 90-day assessment -December 9, 2024, 90-day assessment -December 29, 2024, RN assessment for change in condition done 14 days after R1's return to the facility following a five-day hospitalization. The licensee's RN failed to complete a timely comprehensive assessment for a change in condition regarding the above listed hospitalization. On January 15, 2025, at 9:55 a.m., clinical nurse supervisor (CNS)-B stated she completed a comprehensive assessment 14 days after R1's return from the hospital, as she understood the nurse was to observe the resident for 14 days after he returned and then assess. CNS-B stated she misunderstood the requirement to complete an assessment for a change in condition needed to be completed upon returning from the hospital. The licensee's Initial and Ongoing Assessments dated January 18, 2024, indicated: A RN [registered nurse] will complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: a. Pre-Admission Assessment b. 14-day assessment: completed up to 14-days after start of services c. Ongoing assessment: completed periodically but no less than every 90-days	01620		

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	30659	A. BUILDING: _____ B. WING _____	01/15/2025

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01620	Continued From page 21 d. Change in resident condition No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications stored in a community refrigerator were securely stored. Furthermore, the licensee failed to ensure medications were stored according to manufacturer's recommendations for one of 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 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: On January 13, 2025, at 11:00 a.m. during entrance conference, clinical nurse supervisor	01880		

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	30659	A. BUILDING: _____ B. WING _____	01/15/2025

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01880	Continued From page 22 (CNS)-B stated resident medications were securely stored in a medication cabinet and medications that required refrigeration were stored in the facility's community kitchen refrigerator. On January 13, 2025, at 2:00 p.m., the surveyor and unlicensed personnel (ULP)-C reviewed the contents of the kitchen refrigerator and noted there were unsecured insulin pens in a zip lock bag sitting in the refrigerator door compartment. The refrigerator temperature log indicated ongoing temperature monitoring with the current temperature of 40 degrees Fahrenheit (F). The contents of the bag included insulin pens for R1: -Lispro Kwik pen insulin 100 units/milliliter (u/ml)- six pens (five unopened, one in use) -Tresiba insulin 100 u/ml- four pens (three unopened, one in use) -Ozempic 2 milligrams (mg)/ml- one pen (unopened) The in-use Lispro Kwik Pen was stored in the refrigerator and not at room temperature. Lispro Kwik Pen manufacturer's instructions dated July 2023, indicated for in-use Pen: - Store the Pen you are currently using at room temperature [up to 86°F]. Keep away from heat and light. R1's comprehensive RN assessment dated December 29, 2024, included his medication plan, and indicated medications were stored in a locked compartment, and only staff had access. The licensee failed to ensure medications stored in the refrigerator were securely stored (locked)	01880		

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01880	Continued From page 23 and the in use Lispro insulin was properly stored at room temperature per manufacturer's recommendations. On January 13, 2025, at 2:05 p.m., clinical nurse supervisor (CNS)-B stated she was not aware the insulin pens stored in the kitchen refrigerator would need to be securely locked, and stated after thinking about it, realized all residents had access to the contents of the refrigerator. CNS-B stated she and licensed assisted living director/registered nurse (LALD/RN)-A would immediately purchase a small refrigerator and place in the downstairs locked office and secure the insulin properly. CNS-B further stated both unopened and opened insulin pens were kept in the refrigerator. The licensee's Storage of Medications policy dated September 22, 2023, indicated the registered nurse (RN) will recommend where medications should be stored understanding that our agency may not be able to control where and how a resident stores his/her medications in their room. The RN will provide education to the resident/resident's representative on proper storage of medications in the home including the need to be refrigerated, or stored in a cool, dry area, and according to manufacturer's recommendations. This may include a combination of the resident's room and the nursing office. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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01890	Continued From page 24	01890		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications included an open date for one of four residents (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 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 January 13, 2025, at 2:00 p.m., the surveyor and unlicensed personnel (ULP)-C reviewed the contents of medications stored in the main kitchen refrigerator. Medications were stored in a zip lock bag in the door of the refrigerator. Inside the zip lock bag were opened/currently in-use insulin pens for R1. The pens were labeled as: -Lispro Kwik Pen 100 units/milliliter (u/ml) -Tresiba insulin pen 100 u/ml Neither pen included an open date as required.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30659	A. BUILDING: _____ B. WING _____	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOMES ASSISTED LIVING	3686 KENOSHA DRIVE NW ROCHESTER, MN 55902

(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
01890	Continued From page 25 Lispro Kwik Pen manufacturer's instructions dated July 2023, indicated for in-use Pen: - Store the Pen you are currently using at room temperature [up to 86°F]. Keep away from heat and light. - Throw away the Insulin Lispro Pen you are using after 28 days, even if it still has insulin left in Tresiba insulin pen 100 u/ml manufacturer's instructions dated July 2022, indicated opened/in-use insulin could be stored at room temperature or refrigerated (36 to 46 degrees Fahrenheit) for 56 days. On January 13, 2025, at 1:50 p.m., clinical nurse supervisor (CNS)-B stated the insulin pens should have an open date once in use. The licensee's Storage of Medications dated September 22, 2023, indicated the registered nurse (RN) will provide education to the resident/resident's representative on proper storage of medications in the home including the need to be refrigerated, or stored in a cool, dry area, and according to manufacturer's recommendations. This may include a combination of the resident's room and the nursing office. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01890		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30659	A. BUILDING: _____ B. WING _____	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOMES ASSISTED LIVING	3686 KENOSHA DRIVE NW ROCHESTER, MN 55902

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01940	Continued From page 26 services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services 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 interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of 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	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30659	A. BUILDING: _____ B. WING _____	01/15/2025

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SUNSET HOMES ASSISTED LIVING	3686 KENOSHA DRIVE NW ROCHESTER, MN 55902

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01940	Continued From page 27 cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on January 13, 2025, at 11:00 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatment management services to residents, including blood sugar checks. R1 was admitted to the facility under the Assisted Living Facility (ALF) license on August 1, 2021, with diagnoses including type 2 diabetes, depression, and hypertension. R1's Service Plan dated January 9, 2025, indicated he received services to include medication administration, blood sugar management, and bathing reminders. On January 13, 2025, at 11:45 a.m. unlicensed personnel (ULP)-C observed R1 checking his blood sugar level with his Dexcom sensor/monitor (a unit that provides continuous blood sugar levels). R1's blood sugar reading was 106. ULP-C then recorded his reading on a document labeled Blood Sugar Record. ULP-C stated R1 was independent with using his Dexcom monitor, and the staff were to monitor his use and record the reading. ULP-C stated she was not aware of blood sugar parameters that would need to be reported to the nurse. The Blood Sugar Record lacked parameters for the ULP to contact the registered nurse (RN). R1's assessment dated December 29, 2024,	01940		

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SUNSET HOMES ASSISTED LIVING	3686 KENOSHA DRIVE NW ROCHESTER, MN 55902

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01940	Continued From page 28 included Medication and Treatment plan information, and indicated "resident understands well instructions of self-administration of insulin. He has Dexcom, a continuous glucose [blood sugar] monitoring device on his upper arm. He checks his blood sugar prior to administering his scheduled insulin. Staff records the amount of blood sugar reading each time. Resident does not inject himself with insulin if he doesn't want to eat. Staff to update RN for follow up. Please refer to individual plan of care. R1's treatment record lacked the required content to include: - documentation of specific resident instructions relating to the treatments or therapy administration to include blood sugar parameters; and - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services On January 14, 2025, at 1:00 p.m., clinical nurse supervisor (CNS)-B stated she had a call into R1's provider for further directions. She further stated, "I know I need to identify parameters for R1's blood sugars. [R1] has had a few low blood sugars and some recent insulin dose adjustments." The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated January 18, 2024, indicated the RN may delegate to unlicensed personnel the task of providing assistance with self-administration of medications or may delegate administration of medications, treatment, and therapy if the unlicensed personnel have satisfied the training requirements listed above if:	01940		

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01940	Continued From page 29 a. Before performing the procedures, the RN has instructed the unlicensed personnel in the proper methods to administer the medications, treatment and therapy and the unlicensed personnel have demonstrated the ability to competently follow the procedures. b. The RN has developed written, specific instruction for each resident c. The RN has communicated with the unlicensed personnel about the individual needs of the resident; No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

Minnesota Department of Health
Environmental Health - FPLS

Rochester

Type: Full
Date: *01/14/25*
Time: 09:44:00
Report: 1038251006

Food and Beverage Establishment Inspection Report

Location:
Sunset Homes Assisted Living
3686 Kenosha Drive Nw
Rochester, MN55902
Olmsted County, 55

Establishment Info:
ID #: 0038487
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5073228055
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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Chlorine: = 200ppm at Degrees Fahrenheit
Location: Sanitizer
Violation Issued: No

Hot Water: = at 160 Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 149 Degrees Fahrenheit - Location: Ground Hamburger
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: Milk
Violation Issued: No

Process/Item: Upright Freezer
Temperature: 0 Degrees Fahrenheit - Location: Pizza Rolls
Violation Issued: No

Process/Item: Upright Freezer
Temperature: 0 Degrees Fahrenheit - Location: Buns
Violation Issued: No

Type: Full
Date: *01/14/25*
Time: 09:44:00
Report: 1038251006
Sunset Homes Assisted Living

Food and Beverage Establishment Inspection Report

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

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 1038251006 of 01/14/25.

Certified Food Protection Manager: Jane Nyamwaro

Certification Number: FM111915 Expires: 07/16/25

Signed:_____
Establishment Representative

Signed:_____
Rob Davis
Sanitarian 2
Rochester District Office
507-810-9902
rob.davis@state.mn.us