DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 27, 2022

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

RE: Project Number(s) SL27053015

Dear Administrator:

On April 8, 2022, the Minnesota Department of Health completed a follow-up evaluation of your agency to determine correction of orders found on the evaluation completed on December 30, 2021. The follow-up evaluation determined your agency had not corrected all of the state licensing orders issued pursuant to the December 30, 2021 evaluation.

In accordance with Minn. Stat. § 144A.474, Subd. 11, state licensing orders issued pursuant to the last evaluation completed on December 30, 2021, found not corrected at the time of the April 8, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0470-Minimum Requirements-144g.41 Subdivision 1 = $500.00
0550-Resident Grievances; Reporting Maltreatment-144g.41 Subd. 7 = $500.00
0660-Tuberculosis Prevention And Control-144g.42 Subd. 9 = $500.00
0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 = $500.00
1470-Content Of Required Orientation-144g.63 Subd. 2 = $500.00

The details of the violations noted at the time of this follow-up evaluation completed on April 8, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144A.43 to 144A.482, **the total amount you are assessed is $2,500.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144A.474, Subd. 8(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the home care provider's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144A.475 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144A.475.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144A.475.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144A.474, Subd. 12, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144A.474, Subd. 11(g) , a home care 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. § 144A.475, Subd. 4 and Subd. 7, a request for a hearing must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

We urge you to review these orders carefully. If you have questions, please contact Jodi Johnson at 507-344-2730.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your agency's Governing Body.

Sincerely,

Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 507-344-2730 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27053	A. BUILDING: _____ B. WING _____	R 04/08/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: Project # SL27053015 On April 4, 5 and 8, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on December 30, 2021. At the time of the survey, there were six (6) residents receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	{0 470}		

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{0 470}	Continued From page 1 determining its staffing level that: (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, interview and record review, the licensee failed to ensure the staffing plan contained the required content and a 24 hour staff schedule was posted 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	{0 470}		

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{0 470}	Continued From page 2	{0 470}		

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:

STAFFING PLAN
The licensee's Staffing Plan undated, lacked documented evidence for the following:
- an evaluation of the appropriateness of staffing levels in the facility

STAFFING SCHEDULE
On April 4, 2022, at 10:30 a.m. "Employee Schedule 2-WEEK CYCLE" was observed posted in a hallway on a bulletin board. The schedule included staff names, days of the week, various hours of work as "7-12 pm" or indicated "N [night], D [day].

The posted schedule lacked the following:
- direct-care staff work schedules for each direct-care staff member showing all hours worked;
- 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 April 4, 2022, at 10:59 a.m. licensed assisted living director (LALD)-A stated the date for the staffing plan was January 5, 2022. LALD-A confirmed the staffing plan lacked the above required content. LALD-A confirmed the staffing schedule was posted for a two week cycle and

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{0 470}	Continued From page 3 lacked the above information. LALD-A confirmed the staff schedule was not posted at the beginning of each work shift as required. No further information was provided.	{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: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{0 480}		
{0 550} SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances.	{0 550}		

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{0 550}	Continued From page 4 The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post information related to the grievance procedure, resident advocacy information, and information for reporting suspected maltreatment. 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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee lacked postings in a conspicuous location and a disclosure of resident advocacy to include: - a posting with all required content of the licensee's grievance procedure and the name and email contact information for the individuals who are responsible for handling grievances; - contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; and	{0 550}		

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{0 550}	Continued From page 5 - number and contact information and information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). On April 4, 2022, at approximately 10:30 a.m. no posted facility grievance procedure was observed in any area of the facility. On April 5, 2022, at 9:25 a.m. licensed assisted living director (LALD)-A confirmed the licensee's grievance procedure was not posted in a conspicuous place. LALD-A stated he had given a copy of the grievance procedure to the residents. No further information was provided.	{0 550}		
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced	{0 660}		

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{0 660}	Continued From page 6 by: Based on interview and record review the licensee failed to establish and maintain a TB (tuberculosis) prevention and control program based on the most current guidelines issued by the centers for Disease Control and Prevention (CDC) guidelines. 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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee lacked a written TB infection control plan for the procedures to address early recognition, isolation and referral for handling residents with suspected or confirmed active TB; therefore, none of the licensee's employees had received training on their role in the procedure. The licensee's TB Prevention and Control policy dated January 5, 2022, indicated "if a case of suspected or confirmed TB disease is identified among staff or resident's, we assure that appropriate actions will be taken immediately which may include assistance with arrangement for transfer of the resident to an in patient facility while collaborating and cooperating with local public health and MDH (Minnesota Department of Health)". The MDH guidelines, "Regulations for	{0 660}		

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{0 660}	Continued From page 7 Tuberculosis Control in Minnesota Health Care Settings" dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include the following: written TB infection control procedures. On April 5, 2022, at 1:50 p.m. licensed assisted living director (LALD)-A verified the licensee's policy lacked clear written procedures to address early recognition, isolation and referral for handling clients with suspected or confirmed active TB; therefore, none of the licensee's employees would have received training on their role in the procedure. No further information was provided.	{0 660}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must	{0 680}		

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{0 680}	Continued From page 8	{0 680}		

make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.
(c) The facility must meet any additional requirements adopted in rule.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the licensee failed to develop an all-hazards emergency preparedness (EP) program and plan to include Appendix Z required elements and failed to ensure a missing resident policy included all required content. This had the potential to affect all residents in the facility, staff and any visitors.

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

The findings include:

EMERGENCY PREPAREDNESS PLAN
The licensee lacked required information according to Emergency Preparedness: Appendix Z.

The licensee's Emergency Sheltering, Relocation and Evacuation Plan was dated January 5, 2022.

The licensee lacked the following required

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{0 680}	Continued From page 9 information according to Emergency Preparedness: Appendix Z: - risk assessment which considered hazards like care related emergencies, cyber-attacks, normal supply of essential resources and medical supplies, should consider duration of interruptions, consider emerging infectious diseases (EIDs), arrangements/contracts to re-establish utility services; - document risk assessment for an all hazards approach, including EIDs as applicable, categorize the various probable risks by likelihood of occurrence, develop strategies for addressing facility and community based risks (evacuation plans, staffing surges/shortages, back-up plans); - identification of at risk population needs like maintaining independence, communication, transportation, supervision, medical care, identify which staff would assume specific roles in another's absence through succession planning and delegation of authority and qualified person authorized in writing to act in the absence of the administrator; - a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - policy and procedure based on the EP risk assessment and communication plan; - policy and procedure addressing whether evacuated or shelter in place for staff/residents for food, water, medical supplies, pharmaceutical supplies; - policy and procedure addressing alternate sources of energy to maintain temperatures to protect resident health/safety, safe and sanitary storage of provisions emergency lighting and sewage and waste disposal; - policy and procedure for a system to track the location of on duty staff and sheltered residents and if on duty staff and sheltered residents are	{0 680}		

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{0 680}	Continued From page 10	{0 680}		

relocated, the facility must document the specific name/location of the receiving facility or other location;
- policy and procedure addressing safe evacuation form facility, including care and treatment needs of evacuees; staff responsibilities; primary/alternate communication means with external sources of assistance;
- policy and procedure to shelter in place for residents, staff, and volunteers who remain in the facility;
- policy and procedure addressing system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records;
- policy and procedure addressing use of volunteers, including the process/role for integration;
- policy and procedures addressing development of arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents;
- policy and procedure addressing the role of facility under waiver declared by the Secretary in accordance with section 1135 of the ACT;
- develop a written communication plan;
- communication plan which includes names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, volunteers;
- communication plan which includes contact information for Federal, State, tribal, regional and local EP staff; State Licensing and Certification Agency; MN Office of Ombudsman for LTC and other sources of assistance;
- communication plan which includes primary and alternate means of communication with facility staff and Federal, State, tribal, regional and local emergency management agencies;

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{0 680}	Continued From page 11 - communication plan which includes method for sharing information and medical documentation for residents under the facility's care, as necessary, with other health care personnel to maintain continuity of care; means, in event of evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii); means of providing information about general condition/location of residents under facility's care as permitted under 45 CFR 164.510(b)(4); - communication plan which includes means to providing information about the facility occupancy, needs, and it's ability to provide assistance, to the authority having jurisdiction, the incident command center, or designee; and - communication plan which includes method for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families/representatives; - develop and maintain an EP training and testing program; - training program which includes initial training in EP policy and procedure to all new and existing staff, individuals providing services under arrangement, volunteers consistent with their expected role; provide EP training at least annually; maintain documentation of all EP training; demonstrate staff knowledge of EP; - conduct exercises to test EP at least twice per year, including unannounced staff drills using EP, including participating in an annual full-scale exercise community based or annual individual facility based functional exercise or if facility experiences an actual emergency requiring evacuation of plan, facility is exempt form engaging in its next required full scale exercise; conduct an additional annual exercise that may include a second full scale exercise community based or an individual; facility based functional exercise or mock disaster drill or table top	{0 680}		

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

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{0 680}	Continued From page 12 exercise; - if part of a health care system consisting of separately certified healthcare facilities elects to have a unified and integrated EPP, they may choose to participate and if elected demonstrate each separately certified within the system actively participated in the development of the unified and integrated EPP. If elected the EPP demonstrates that each separately certified within the system actively participated in the development of the unified and integrated EPP, including developing/maintaining in a manner that takes into account each separately certified facility's unique circumstances, patient populations, and services offered; demonstrate each separately certified facility is capable of actively using the unified/integrated EPP and in in compliance with the program; include unified/integrated EP that meets requirements including documented community-based risk assessment, utilizing an all hazards approach; documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing and all hazards approach and include integrated policy and procedure that meet requirements set forth. MISSING RESIDENT POLICY The licensee's Missing Resident policy dated January 5, 2022, was a copy of the statutory language and was not modified to licensee's specifics for the following: - identify a staff member for each shift who is responsible for implementing the missing resident plan, and ensure at least one staff member who is responsible for implementing the missing resident plan is onsite 24 hours a day, seven days a week; - require that the staff alert the staff member identified in sub item (1) immediately if it is	{0 680}		

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{0 680}	Continued From page 13 suspected that a resident may be missing; - identify staff by position description who are responsible for searching for missing residents or suspected missing residents; On April 4, 2022, at 11:57 a.m. licensed assisted living director (LALD)-A stated for the licensee's EP plan he had "pulled up appendix Z and tore it down to what pertains" to site, "because of the size of who we are." LALD-A verified had not completed a risk assessment as required and had not developed a communication plan. LALD-A stated the EP plan would be integrated as he owned three separate licensed assisted living facilities, and if evacuation of the facility was needed, the residents would evacuate to one of the other assisted living sites. LALD-A verified the licensee's Missing Resident policy lacked the required information. No additional information was provided.	{0 680}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: No further action required.	{0 800}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	{0 810}		

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{0 810}	Continued From page 14 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required.	{0 810}		

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{0 900}	Continued From page 15	{0 900}		
{0 900} SS=A	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed.	{0 900}		

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{0 900}	Continued From page 16 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R2) with record reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 began receiving assisted living services on August 1, 2021. R2's Service Plan was dated effective April 5, 2022. The service plan lacked signature and date or other authentication by the licensee and by the resident documenting agreement on the services to be provided. R2's Resident Agreement Assisted Living was signed by R2 on February 3, 2022. The Resident Agreement indicated "If you require health and supportive services beyond those included in the monthly base fee, a written service plan will be established for you and attached to this agreement as Attachment D (the 'Service Plan')." Attachment D Service Plan was a checklist for "General Contents" of what should be included on a service plan; however, R2's service plan was not attached as required. On April 5, 2022, at 9:50 a.m. licensed assisted	{0 900}		

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{0 900}	Continued From page 17 living director (LALD)-A confirmed R2 had a service plan and R2's service plan was not attached to the contract as required. No further information was provided.	{0 900}		
0 920 SS=C	144G.50 Subd. 2 Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be discharged, evicted, or transferred or have services terminated; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R2)	0 920		

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0 920	Continued From page 18 with record reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2's Resident Agreement Assisted Living was signed by R2 on February 3, 2022. The contract indicated "Additional Services" in addition to the included services, certain other services are available at the community for additional fees ("Additional Services"). Descriptions and pricing of additional services are included on "Attachment A;" however, there was no attachment A included with R2's contract. R2's contract lacked the following required content: - a disclosure that it does not hold an assisted living facility with dementia care license; - a delineation of the cost and nature of any other services to be provided for an additional fee; and - a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract On April 5, 2022, at 9:50 a.m. licensed assisted living director (LALD)-A confirmed the licensee's contract for all residents lacked the above. LALD-A stated the licensee "did not have any additional services" which they would charge for	0 920		

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0 920	Continued From page 19 and the contract should not reference attachment A. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 920		
0 930 SS=C	144G.50 Subd. 2 Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R2) with record reviewed.	0 930		

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0 930	Continued From page 20 This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2's Resident Agreement Assisted Living was signed by R2 on February 3, 2022. The contract indicated "All oral and written complaints will be directed to the LALD (licensed assisted living director);" however, the licensee had more than one LALD and the contract did not indicate who the LALD was or the contact information of the LALD responsible. R2's contract lacked the following required content: - the name and contact information of the person representing the facility who is designated to handle and resolve complaints On April 5, 2022, at 9:50 a.m. licensed assisted living director (LALD)-A confirmed the licensee's contract for all residents lacked the above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 930		

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0 940	Continued From page 21	0 940		
0 940 SS=C	144G.50 Subd. 2 Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center.	0 940		

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0 940	Continued From page 22 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R2) with record reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2's Resident Agreement Assisted Living was signed by R2 on February 3, 2022. R2's contract lacked the following required content: - a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program On April 5, 2022, at 9:50 a.m. licensed assisted living director (LALD)-A confirmed the licensee's contract for all residents lacked the above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 940		
{01380} SS=E	144G.61 Subd. 2 Training and evaluation of unlicensed personn	{01380}		

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{01380}	Continued From page 23 (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure competency evaluations were completed as required prior to providing direct care for two of two unlicensed personnel (ULP-D, ULP-E) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include:	{01380}		

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{01380}	Continued From page 24 ULP-D had a hire date of June 23, 2017. ULP-D's Comprehensive Home Care Regulatory Compliance Checklist for New Home Care Employees indicated "all required background checks and screenings, orientation and initial training or competency determination have been completed" and date successfully completed was June 29, 2017, for the topic: -safe transfer techniques ULP-D's record lacked documented evidence of a written procedure and indication of pass or fail for competency evaluation of safe transfer techniques. ULP-E had a hire date of October 30, 2020. ULP-E's record lacked evidence of documented training and a written procedure and indication of pass or fail for competency evaluation for the topic of: -safe transfer techniques On April 5, 2022, at approximately 12:16 p.m. licensed assisted living director (LALD)-A verified ULP-D and ULP-E's records lacked evidence of training and competency for the required topic above. A policy for employee training and competency was requested, but not provided. No further information was provided.	{01380}		
{01470} SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following	{01470}		

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{01470}	Continued From page 25	{01470}		

topics:
(1) an overview of this chapter;
(2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;
(3) handling of emergencies and use of emergency services;
(4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);
(5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;
(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;
(7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;
(8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and
(9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure.
(b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following

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	27053	A. BUILDING: _____ B. WING _____	R 04/08/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{01470}	Continued From page 26	{01470}		

topics:
(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;
(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or
(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for two of two unlicensed personnel (ULP-D, ULP-E) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), 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:

ULP-D had a hire date of June 23, 2017.

ULP-D's record lacked documented evidence of orientation to assisted living regulations (144G.63, Sub. 2) effective August 1, 2021, for

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{01470}	Continued From page 27 the following: - an overview of this chapter (assisted living statutes); and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person ULP-E had a hire date of October 30, 2020. ULP-E's record lacked documented evidence of orientation to assisted living regulations (144G.63, Sub. 2) effective August 1, 2021, for the following: - an overview of this chapter (assisted living statutes) On April 5, 2022, at approximately 12:16 p.m. licensed assisted living director (LALD)-A verified ULP-D and ULP-E's records lacked evidence of orientation training for the required topics above. LALD-A confirmed he had not completed an overview of the assisted living statutes with any of the licensee's employees. LALD-A stated he had trained employees on the licensee's policy and procedures and that qualified for the overview of the assisted living statutes. A policy for employee orientation was requested, but not provided. No further information was provided.	{01470}		
{01500} SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another	{01500}		

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{01500}	Continued From page 28	{01500}		

source and must include topics relevant to the provision of assisted living services. The annual training must include:
(1) training on reporting of maltreatment of vulnerable adults under section 626.557;
(2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;
(3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;
(4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;
(5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and 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

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{01500}	Continued From page 29	{01500}		

and how it manifests itself, its prevalence, and challenges it poses to communication;
(2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or
(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of two employees (unlicensed personnel (ULP)-D) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

ULP-D had a hire date of June 23, 2017.

ULP-D's employee record lacked evidence of documented annual training for the following required topics:

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{01500}	Continued From page 30 -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. On April 5, 2022, at approximately 12:16 p.m. licensed assisted living director (LALD)-A verified ULP-D's record lacked evidence of annual training for the required topics above. A policy for annual training of employee was requested, but not provided. No further information was provided.	{01500}		
{01640} SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for	{01640}		

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{01640}	Continued From page 31 Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included a signature or other authentication by the resident and the facility to document agreement on the services provided for two of two residents (R2, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: The licensee lacked a signature and date or other authentication by the licensee and by the resident documenting agreement on the services to be provided for R2 and R3's service plans no later than 14 calendar days after the date that services were first provided.	{01640}		

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{01640}	Continued From page 32 R2's record indicated R2 was admitted to the facility on January 22, 2019. R2's diagnoses included morbid obesity and head injury. R2's Service plan effective date April 5, 2022, lacked signature and date by the licensee and by the resident documenting agreement on the services to be provided. R3's record indicated R3 was admitted to the facility on January 13, 2022. R3's diagnoses included schizoaffective disorder and metabolic syndrome. R3's Service plan effective date April 5, 2022, lacked signature and date by the licensee and by the resident documenting agreement on the services to be provided. On April 5, 2022, at 9:50 a.m. licensed assisted living director (LALD)-A showed surveyor R2's service plan located in the licensee's computer system. The service plan lacked a date and signatures. LALD-A confirmed R2 and R3's service plans were not signed and dated by the licensee and by the resident documenting agreement on the services to be provided. LALD-A stated we talked with each resident regarding the service plan and services to be provided. No further information was provided.	{01640}		
{01650} SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to	{01650}		

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{01650}	Continued From page 33 (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan included all required content for one of one resident (R2) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	{01650}		

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{01650}	Continued From page 34	{01650}		

cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R2's diagnoses included morbid obesity and head injury.

On April 5, 2022, at 8:13 a.m. unlicensed personnel (ULP)-D was observed to administer medications to R2.

R2's Med Sheets dated April 2022, identified staff were signing for the service of "CPAP" (continuous positive air pressure) machine and tubing - return CPAP and tubing to the resident's room after making sure it is dry. Put back the parts together in redness for use during the night daily.

R2's Master Care Plan dated December 27, 2021, indicated need for help with other respiratory equipment - staff to clean CPAP tubing every morning and rinse with clean water. Tubing to be left hanging in the bathroom to air dry.

R2's Service Plan effective date April 5, 2022, lacked the description/frequency/fee for the the service of CPAP, including identification of staff or categories of staff who will provide the services.

On April 5, 2022, at 9:50 a.m. licensed assisted living director (LALD)-A confirmed R2's service plan lacked the above content.

No further information was provided.

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{01790} SS=E	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been	{01790}		

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{01790}	Continued From page 36	{01790}		

provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information;
(v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative;
(vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and
(vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure competency evaluations were completed as required for two of two unlicensed personnel (ULP-D, ULP-E) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

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{01790}	Continued From page 37 The findings include: ULP-D had a hire date of June 23, 2017. ULP-E had a hire date of October 30, 2020. ULP-D and ULP-E's records lacked evidence to indicate the registered nurse (RN) provided training and determined competency to prepare and administer medications to residents for unplanned times away. On April 5, 2022, at approximately 12:16 p.m. licensed assisted living director (LALD)-A stated he had trained and competency ULP-D and ULP-E. LALD-A confirmed there was no training and competency documented for the task of medication administration for unplanned time away in ULP-D and ULP-E's records. LALD-A stated the information was probably on the desk at the office. LALD-A stated he would look for and provide the information; however, no further information was provided. A policy for training and competency for medications for unplanned time away was requested, but not provided. No further information was provided.	{01790}		
{03090} SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities."	{03090}		

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{03090}	Continued From page 38 (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff and any visitors of the licensee. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 4, 2022, at approximately 10:29 a.m. posted on the front entrance door was a piece of paper which read "per MN Rule 144G.6502 electronic monitoring and audio recording may be in use in this facility." The posting lacked the statutory language for electronic monitoring of "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities" as required. On April 4, 2022, at 1:12 p.m. licensed assisted living director (LALD)-A verified the posted information did not include the statutory language	{03090}		

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{03090}	Continued From page 39 as required. No further information was provided.	{03090}		

Electronically Delivered

February 1, 2022

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

RE: Project Number(s) SL27053015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on December 30, 2021, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

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

The total amount you are assessed is $500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

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

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

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jodi.johnson@state.mn.us
Telephone: 507-696-2437 Fax: 651-215-9697

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27053	A. BUILDING: _____ B. WING _____	12/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments 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: SL#27053015 On December 28, 2021, through December 30, 2021, 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 six (6)residents receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 250 SS=F	144G.20 Subdivision 1. Conditions (a) The commissioner may refuse to grant a	0 250		

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0 250	Continued From page 1 provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the	0 250		

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0 250	Continued From page 2 commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the management officials who were in charge of the day-to-day operations; and responsible for the assisted living services, understood all of the assisted living provider statues and rules; and the licensee failed to ensure policies and procedures were developed and/or implemented. 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 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: During the entrance conference on December 28, 2021, at approximately 9:34 a.m. licensed assisted living director (LALD)-A confirmed he was responsible for and participated in the	0 250		

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0 250	Continued From page 3 facility's day-to-day operations. LALD-A stated he was familiar with the Assisted Living licensing laws and rules. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45 (opens in a new window), my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17 (opens in a new window). - I have read and fully understand Minn. Stat. sect. 144G.80 (opens in a new window), 144G.81 (opens in a new window). and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22 (opens in a new window), my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G (opens in a new window). - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659 (proposed and not final) (opens in a new window). - Reporting of Maltreatment of Vulnerable Adults (opens in a new window). - Electronic Monitoring in Certain Facilities (opens in a new window). - I understand pursuant to Minn. Stat. sect. 13.04	0 250		

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0 250	Continued From page 4 Rights of Subjects of Data (opens in a new window), the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G (opens in a new window), and Minnesota Rules, chapter 4659 (proposed and not final) (opens in a new window), governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of	0 250		

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0 250	Continued From page 5 the existence of a management agreement or subcontract. - I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G (opens in new window). and Minn. Rules chapter 4659 (proposed and not final) (opens in new window), in place upon licensure and to keep them current as applicable. Page five was electronically signed by the owner on May 17, 2021. The licensee had an Assisted Living license issued on August 1, 2021. The licensee lacked development of the following policies and procedures for: -orientation to and implementation of the assisted living bill of rights; -reminders for treatments, or exercises; -ensuring that nurses and licensed health professionals have current and valid licenses to practice; and -supervision of registered nurses and licensed health professionals On December 28, 2021, at 1:06 p.m. licensed assisted living director (LALD)-A stated the licensee had not updated or developed policies	0 250		

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0 250	Continued From page 6 and procedures for the new Assisted Living regulations. On December 29, 2021, at 2:51 p.m. LALD-A and LALD-B verified the licensee lacked development of the above listed policies and procedures. In addition, the licensee failed to implement the following required policies and procedures: - infection control practices; - requirements in section 626.557, reporting of maltreatment of vulnerable adults; - orientation, training, and competency evaluations of staff; - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; - medication management; - delegation of tasks by registered nurses or licensed health professionals; and - orientation to and implementation of the assisted living bill of rights Refer to licensing order at Statute 144G.41, Subd. 3. The licensee failed to establish and maintain an effective infection control program to comply with current recommendations for COVID-19. Refer to licensing order at Statute 144G.42, Subd 6 (b). The licensee failed to develop and implement an individual abuse prevention plan that included an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults and the person's risk of abusing	0 250		

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0 250	Continued From page 7 other vulnerable adults for one of one resident (R1) with record reviewed. Refer to licensing order at Statute 144G.42, Subd 8. The licensee failed to ensure an annual performance evaluation was completed for one of two unlicensed personnel (ULP-D) with records reviewed. Refer to licensing order at Statute 144G.42, Subd. 9. The licensee failed to establish and maintain a TB (tuberculosis) prevention and control program based on the most current guidelines issued by the centers for Disease Control and Prevention (CDC) guidelines. Refer to licensing order at Statute 144G.61, Subd. 2 (a)(b). The licensee failed to ensure training and competency evaluations contained all the required training for two of two unlicensed personnel (ULP-C, ULP-D) with records reviewed. Refer to licensing order at Statute 144G.63, Subd. 2. The licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for two of two unlicensed personnel (ULP-C, ULP-D) with records reviewed. Refer to licensing order at Statute 144G.63, Subd. 3. The licensee failed to ensure staff providing assisted living services were oriented specifically to each individual resident and the services to be provided for for two of two unlicensed personnel (ULP-C, ULP-D) with records reviewed. Refer to licensing order at Statute 144G.63,	0 250		

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0 250	Continued From page 8 Subd. 5. The licensee failed to ensure annual training included all required topics for each 12 months of employment for one of two employees unlicensed personnel (ULP-D) with records reviewed. Refer to licensing order at Statute 144G.64, (a)(2). The licensee failed to ensure direct-care staff completed the required amount of dementia care training in the required time frame for two of two unlicensed personnel (ULP-C, ULP-D) with records reviewed. Refer to licensing order at Statute 144G.70, Subd. 2. The licensee failed to ensure reassessment and monitoring for one of one resident (R1) with record reviewed. Refer to licensing order at Statute 144G.71, Subd. 2. The licensee failed to ensure the registered nurse (RN) conducted a medication management assessment for one of one resident (R1) with record reviewed. Refer to licensing order at Statute 144G.71, Subd. 3. The licensee failed to ensure monitoring and reassessment of the resident's medication management services at a minimum annually for one of one resident (R1) with record reviewed. Refer to licensing order at Statute 144G.71, Subd. 8. The licensee failed to ensure medication was not administered as ordered for one of one resident (R1) with record reviewed. Refer to licensing order at Statute 144G.71, Subd. 10. (a)(2). The licensee failed to ensure two of two unlicensed personnel (ULP-C, ULP-D) were trained and had demonstrated competency to prepare and give medications for clients having	0 250		

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0 250	Continued From page 9 unplanned time away. Refer to licensing order at Statute 144G.71, Subd. 14. The licensee failed to ensure prescriptions were renewed at least every 12 months for one of one resident (R1) with record reviewed. Refer to licensing order at Statute 144G.71, Subd. 19. The licensee failed to ensure access to keys for a medication cart was secure. Refer to licensing order at Statute 144G.90, Subd. 1. The licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents was provided to the residents and a written acknowledgement received for one of one resident (R1) with record reviewed. Thirty-seven (37) correction orders were issued, which indicated the licensee's understanding of the Minnesota statutes were limited or not evident for compliance with sections 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 250		
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted	0 430		

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0 430	Continued From page 10 under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a copy of the uniform disclosure of assisted living services and amenities (UDALSA) prior to providing assisted living services, for one of one resident (R1) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 began receiving assisted living services on August 1, 2021. R1's Admission and Service Plan Agreement dated July 18, 2019, indicated the basic services	0 430		

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0 430	Continued From page 11 offered to all clients included, but were not limited to, medication management services ("RN" (registered nurse) medication need assessment, administration, set-up, monitoring, reminders and ordering), meal service (preparation, set-up and monitoring for choking), laundry services, non-medical support services (shopping, community access), socialization activities, housekeeping services, mental health management services (orientation, wondering, anxiety, behavior, cognitive needs, agitation, etc.) assistance with activities of daily living (dressing, grooming, continence care, positioning, bathing, walking, wheeling, transferring, etc.) clinical monitoring services (INR [international normalized ratio] lab results for blood clotting), blood pressure, blood sugar, insulin administration, etc.), on site staff 24/7 days, call system device for each client to use in summoning help from staff when need. On December 28, 2021, at 11:42 a.m. unlicensed personnel (ULP)-C was observed to administer medications to R1. R1's record lacked evidence the resident had received a copy of the UDALSA prior to receiving services on August 1, 2021. On December 28, 2021, at 9:34 a.m. licensed assisted living director (LALD)-A stated he was unaware of what the UDALSA was. LALD-A confirmed the current residents had not received the UDALSA. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided.	0 430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27053	A. BUILDING: _____ B. WING _____	12/30/2021

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

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0 430	Continued From page 12 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (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, interview and record review, the licensee failed to ensure the staffing	0 470		

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0 470	Continued From page 13 plan was developed to determine staffing levels to meet the needs of all residents, and the 24-hour staffing schedule was posted 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 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: STAFFING PLAN The licensee failed to develop and implement a staffing plan for determining its staffing level that: - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; - ensured 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 - ensured 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 STAFFING SCHEDULE The licensee lacked a posted daily staffing schedule developed by the clinical nurse supervisor to include: -direct-care staff work schedules for each direct-care staff member showing all work shifts,	0 470		

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0 470	Continued From page 14 including days and hours worked; -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 December 28, 2021, at approximately 10:44 a.m., no posted staff schedule was observed in any area of the facility. On December 28, 2021, at 9:34 a.m. licensed assisted living director (LALD)-A stated he was unaware of the requirement for the licensee to develop and implement a staffing plan. At 1:19 p.m., LALD-A confirmed a staffing schedule was not posted in a central location. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. 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: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA)	0 480		

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0 480	Continued From page 15 guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, 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 according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated December 28, 2021, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 485 SS=F	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the	0 485		

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0 485	Continued From page 16 following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure menus were provided to residents, and residents were informed in advance of menu changes. This had the potential to affect all six (6) residents. 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:	0 485		

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0 485	Continued From page 17 On December 28, 2021, at 11:33 a.m. residents were observed eating chicken nuggets, broccoli, chili beans, green beans and drinking milk or pop. At that time, unlicensed personnel (ULP)-C stated there was a "menu in a book" to follow for meals to be served. ULP-C verified he had prepared the food served to the residents for lunch and stated, "[licensed assisted living director (LALD)-B] brings food prepared" to the facility. ULP-C provided the surveyor with weekly menus located in a binder and stated, "the menu for the week was week two". The menu for week two indicated for lunch, the food to be served was tater tot hotdish, breadsticks, cottage cheese/pineapple, coffee/tea, juice or milk. On December 28, 2021, at 11:54 a.m. ULP-C verified he had not followed the menu. On December 29, 2021, at 8:26 a.m. R1 stated, "No" in regards to seeing the menu and what food would be served. R1 stated, "[LALD-B] does the cooking and menus". R1 stated, "We never know for sure what is going to be served. Some staff wing it". On December 29, 2021, at 2:55 p.m. LALD-A and LALD-B confirmed menus were not posted or provided to the residents and residents were not aware in advance of menu changes. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information provided.	0 485		

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0 485	Continued From page 18 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (ii) weekly housekeeping; (iii) weekly laundry service; (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have a daily program of social and recreational activities. This had the potential to affect all six residents receiving assisted living services.	0 490		

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0 490	Continued From page 19 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 28, 2021, at approximately 9:10 a.m. two residents were observed seated in the living room and a television was turned on. The two residents were sleeping. On December 28, 2021, at 9:34 a.m. licensed assisted living director (LALD)-A stated from "10:00 a.m. to 12:00 p.m. clients can play piano". LALD-A stated, "We don't have a calendar for activities". LALD-A stated, "Prior to COVID" the residents would go to an "activity program outside of the facility". LALD-A stated the residents could "do what they want from 10:00 a.m. to 12:00 p.m." LALD-A stated, "nothing was set in stone" for activities. LALD-A stated the residents had a "fear of COVID and want to be left alone". On December 28, 2021, at 10:48 a.m. unlicensed personnel (ULP)-C stated, "We are not responsible for activities". ULP-C stated, "Other people" were "hired" to take residents to "appointments". ULP-C stated the residents used to "play foosball [a tabletop game of soccer] once a week", but the foosball was "broke now". On December 29, 2021, at 8:26 a.m. R1 stated, "One time a week after the evening meal on Saturday night" was "game night. They have bingo game here." R1 stated he had "ideas" of	0 490		

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0 490	Continued From page 20 what the licensee could do for activities, but no one "takes the time to sit down and listen to me." R1 stated the licensee had "nothing planned or scheduled" for activities in the home or outside of the home in the community. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 490		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an effective infection control program to comply with current recommendations for COVID-19. This had the potential to affect all residents, staff and visitors.	0 510		

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0 510	Continued From page 21 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: The licensee failed to post signage of restrictions for COVID-19 at facility entrances, screen visitors/residents/employees for COVID-19, and ensure employees wore eye protection and a facial mask. In addition, the licensee lacked a written policy and procedure for COVID-19. On December 28, 2021, at 9:10 a.m. upon entrance to the facility, a sign was observed posted which read "stop, do you have fever or cough." There was no signage posted at the facility entrances for screening or restrictions for infection prevention and control for COVID-19. In addition, there was no indication or process for visitors to screen upon entrance for COVID-19 symptoms or to check a temperature. Unlicensed personnel (ULP)-C was present and was not wearing eye protection or a facial mask. At 9:34 a.m., licensed assisted living director (LALD)-A was not wearing eye protection or a facial mask. At 10:48 a.m., ULP-C confirmed he was not wearing eye protection or a facial mask. ULP-C stated, "I have a surgical mask to wear, but I am not wearing it." ULP-C stated he had not been given eye protection to wear. ULP-C stated, "No" to screening visitors, residents and employees for COVID-19. At 12:24 p.m., LALD-B was observed to wear a facial mask, but not eye protection.	0 510		

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0 510	Continued From page 22 R1's record lacked evidence of documented daily screening of temperature and COVID-19 symptoms. The Centers for Disease Control and Prevention (CDC) webpage titled "Symptoms of COVID-19" updated February 22, 2021, indicated "People with COVID-19 have had a wide range of symptoms reported ranging from mild symptoms to severe illness. Symptoms may appear 2-14 days after exposure to the virus. Anyone can have mild to severe symptoms. People with these symptoms may have COVID-19: Fever or chills, Cough, Shortness of breath or difficulty breathing, Fatigue, Muscle or body aches, Headache, New loss of taste or smell, Sore throat, Congestion or runny nose, Nausea or vomiting, Diarrhea, This list does not include all possible symptoms. CDC will continue to update this list as we learn more about COVID-19. Older adults and people who have severe underlying medical conditions like heart or lung disease or diabetes seem to be at higher risk for developing more serious complications from COVID-19 illness". The MDH COVID-19 Guidance: Long-term Care Indoor Visitation for Nursing Facilities and Assisted Living-type Settings guidance dated May 20, 2021, indicated facilities should actively screen all residents for fever and respiratory symptoms of illness at least daily and increase monitoring of ill residents to at least three times daily. The CDC guidance titled, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic updated Sept. 10, 2021, indicated ensure everyone is	0 510		

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0 510	Continued From page 23	0 510		

aware of recommended IPC practices in the facility. Post visual alert icons (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias) with instructions about current IPC recommendations (e.g., when to use source control and perform hand hygiene). Dating these alerts can help ensure people know that they reflect current recommendations. Establish a process to identify anyone entering the facility, regardless of their vaccination status, who has any of the following so that they can be properly managed: 1) a positive viral test for SARS-CoV-2, 2) symptoms of COVID-19, or 3) who meets criteria for quarantine or exclusion from work. Options could include (but are not limited to): individual screening on arrival at the facility; or implementing an electronic monitoring system in which individuals can self-report any of the above before entering the facility. Implement Universal Use of Personal Protective Equipment for HCP If SARS-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), HCP working in facilities located in counties with substantial or high transmission should also use PPE as described below: Facilities could consider use of NIOSH-approved N95 or equivalent or higher-level respirators for HCP working in other situations where multiple risk factors for transmission are present. One example might be if the patient is unvaccinated, unable to use source control, and the area is poorly ventilated. Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all patient care encounters.

The Minnesota Department of Health (MDH) guidance titled, COVID-19 Guidance: Long-term Care Indoor Visitation for Nursing Facilities and

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0 510	Continued From page 24 Assisted Living Settings, updated December 29, 2021, indicated this guidance replaces previous Minnesota Department of Health (MDH) visitation guidance for Minnesota's long-term care settings, such as nursing facilities, skilled nursing facilities, and assisted living facilities. The following core principles of COVID-19 infection prevention are consistent with Centers for Disease Control and Prevention (CDC) guidance and should be adhered to at all times. Refer to #1 on the CMS FAQ. Per CMS QSO 20-39, core principles include: Visitors who have a positive viral test for COVID-19; symptoms of COVID-19; or currently meet the criteria for quarantine, should not enter the facility. Facilities should screen all who enter for these visitation exclusions. Having staff wear face masks and other needed personal protective equipment. On December 29, 2021, at 9:02 a.m. LALD-A stated the licensee had no COVID policies. LALD-A further stated, "I need more guidance on that." LALD-A also stated, "We were doing that" in regards to screening visitors, residents and employees for COVID-19, but "stopped" when residents and employees were "vaccinated." LALD-A stated employees were "encouraged to call" if any symptoms of COVID-19 "before coming to work." LALD-A stated he was aware of the current recommendations for COVID-19, but the licensee "became complacent with things". On December 29, 2021, at 2:47 p.m. LALD-A and LALD-B verified there was no posted signage of restrictions for COVID-19 at facility entrances. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		

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	27053	A. BUILDING: _____ B. WING _____	12/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post information related to the grievance procedure, resident advocacy information, and information for reporting suspected maltreatment. 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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee lacked postings in a conspicuous location and a disclosure of resident advocacy to include:	0 550		

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0 550	Continued From page 26 -a posting with all required content of the licensee's grievance procedure and the name and email contact information for the individuals who are responsible for handling grievances; -contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; and -number and contact information and information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). On December 28, 2021, at approximately 12:20 p.m. no posted facility grievance procedure was observed in any area of the facility. On December 28, 2021, at 1:19 p.m. licensed assisted living director (LALD)-A confirmed the facility grievance procedure was not posted in a conspicuous place. The licensee Complaint Policy and Procedure dated February 25, 2020, indicated each resident and/or resident representative received written notice of the agency's process for receiving and resolving complaints. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 580 SS=F	144G.42 Subd. 2 Quality management	0 580		

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0 580	Continued From page 27 The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity. This had the potential to affect all six (6) residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 28, 2021, at 11:22 a.m. licensed assisted living director (LALD)-A stated the licensee had not had any quality management activity meetings.	0 580		

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0 580	Continued From page 28 A policy for quality management was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 630 SS=D	144G.42 Subd. 6 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 develop and implement an individual abuse prevention plan that included an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults and the person's risk of abusing other vulnerable adults for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 630		

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0 630	Continued From page 29 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: R1's diagnoses included depressive disorder, bipolar disorder and post cerebral vascular accident (CVA). On December 28, 2021, at 11:42 a.m. unlicensed personnel (ULP)-C was observed to administer medications to R1. R1 was observed to have a plastic brace on his left lower leg. R1's Resident Notes dated November 5, 2021, indicated the case worker was notified of alleged drug use and sale activity R1 was conducting in the house. It was determined R1 was taking advantage of other vulnerable residents by selling illegal drugs to them. R1's Individual Abuse Prevention Plan dated December 29, 2021, lacked a response for "Evaluation Options" for "Resident is not at risk to abuse other vulnerable adults" and "Is not at risk to be abused" for an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults and the person's risk of abusing other vulnerable adults. On December 29, 2021, at 11:50 a.m. licensed assisted living director (LALD)-B verified R1's Individual Abuse Prevention Plan lacked an individualized review or assessment for the above content.	0 630		

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0 630	Continued From page 30 A policy for individual abuse prevention plan was requested, but not provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557 as required. This had the potential to affect all six (6) 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	0 640		

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0 640	Continued From page 31 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 December 28, 2021, at approximately 12:20 p.m. the facility was observed to be lacking posting of the MAARC hotline in the common areas of the facility. On December 28, 2021, at 1:19 p.m. licensed assisted living director (LALD)-A confirmed the facility lacked posting of the MAARC hotline in the common areas of the facility. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
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, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training	0 650		

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0 650	Continued From page 32 and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure an annual performance evaluation was completed for one of two unlicensed personnel (ULP-D) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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).	0 650		

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0 650	Continued From page 33 The findings include: ULP-D had a hire date of June 23, 2017. ULP-D's employee record identified a "Performance Review" dated June 25, 2018. ULP-D's employee record lacked evidence of an annual performance review completed after June 15, 2018. On December 28, 2021 at 1:41 p.m. licensed assisted living director (LALD)-A verified the last performance review ULP-D had was dated June 25, 2018. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide	0 660		

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0 660	Continued From page 34 technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to establish and maintain a TB (tuberculosis) prevention and control program based on the most current guidelines issued by the centers for Disease Control and Prevention (CDC) guidelines. 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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee lacked a written TB infection control plan for the procedures to address early recognition, isolation and referral for handling residents with suspected or confirmed active TB; therefore, none of the licensee's employees had received training on their role in the procedure. The licensee's policy TB Control Measures dated February 25, 2020, indicated for environmental controls the licensee "assisted living facility/s with environmental control measures to prevent the spread and reduction of the concentration of infectious droplet nuclei" (aerosols formed from	0 660		

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0 660	Continued From page 35 the evaporation of respiratory droplets). The MDH guidelines, "Regulations for Tuberculosis Control in Minnesota Health Care Settings" dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include the following: written TB infection control procedures. On December 28, 2021, at 12:59 p.m. licensed assisted living director (LALD)-A verified the licensee's policy lacked clear written procedures to address early recognition, isolation and referral for handling clients with suspected or confirmed active TB; therefore, none of the licensee's employees would have received training on their role in the procedure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor;	0 680		

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0 680	Continued From page 36 and (5) have a written policy and procedure regarding missing tenant 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 document review, the licensee failed to ensure emergency exit diagrams were posted and provided to residents. In addition, the licensee failed to develop an all-hazards emergency preparedness (EP) program and plan to include Appendix Z required elements. This had the potential to affect all six (6) residents, staff and any visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: EMERGENCY EXIT DIAGRAM The licensee lacked posted emergency exit diagrams and did not provide building emergency	0 680		

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0 680	Continued From page 37 exit diagrams to all residents. On December 28, 2021, at approximately 10:46 a.m. no posted emergency exit diagrams were observed in any area of the facility. The licensee lacked the following: - a written emergency disaster plan that contained a plan for evacuation, which addressed elements of sheltering in place, identified temporary relocation sites, and detailed staff assignments in the event of a disaster or an emergency; - posting of an emergency disaster plan prominently; - provided building emergency exit diagrams to all residents; - posted emergency exit diagrams on each floor; and - Appendix Z (emergency preparedness) requirements On December 28, 2021, at approximately 10:46 a.m. no posted emergency exit diagrams were observed in any area of the facility and no posted emergency disaster plan was observed in any area of the facility. The licensee provided policies dated February 25, 2020, for "Emergency Procedures/911 Calls" (responding to resident emergencies) and "Plans for Natural Disasters and Emergencies", which indicated the agency would have a written plan of action to facilitate the residents care and services in response to a natural disaster or another type pf emergency that may affect the ability of the agency to provide services. The policy indicated the plan would be updated regularly and would be coordinated with local emergency responders and staff would be trained on actions to take during a	0 680		

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0 680	Continued From page 38 natural disaster or other type of procedure (protecting residents in buildings during fires, weather emergencies or other type of emergencies). The policy further addressed contingency plan for residents (part of service plan), staff training for emergency situation (calling 911 and summoning emergency responders, alert to severe weather warnings, getting resident to safety in case of fire/severe weather or other disasters, what types of symptoms indicate medical emergency when 911 and registered nurse should be called) and home care staff working in senior housing (staff training on the building's procedure for fire, weather emergencies, loss of power and similar emergencies, providing emergency contact information for building management staff, participating in building fire drills or drills for severe weather). On December 28, 2021, at 1:19 p.m. licensed assisted living director (LALD)-A confirmed there were no posted emergency exit diagrams in the facility. LALD-A stated, "No" to providing building emergency diagrams to all residents. LALD-A confirmed there was no emergency disaster plan posted prominently in the facility. LALD-A stated, "What's that," in regards to Appendix Z content. LALD-A confirmed the licensee lacked an all-hazards emergency preparedness program and plan. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27053	A. BUILDING: _____ B. WING _____	12/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights;	0 730		

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0 730	Continued From page 40 (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure documentation of services provided for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's record lacked documentation of services provided by the licensee. On December 28, 2021, at 11:42 a.m. unlicensed personnel (ULP)-C was observed to administer medications to R1. R1's record lacked a finalized written service plan. R1's Service Chart Monthly dated December 2021, indicated the services being documented	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27053	A. BUILDING: _____ B. WING _____	12/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 730	Continued From page 41 by staff as provided included medication assist, activity assist, ambulation/exercises, appointment reminder assist, behavior irritability, care for personal possession assist, clothing assist, dressing a.m. and p.m., grooming, meal assistance, meal tray, record blood pressure 1st Sunday, record pulse 1st Sunday, record temperature 1st Sunday, record weight 1st Sunday, report pain, safety check, shopping assist, transportation assist, bathing, laundry and skin care. The Service Chart Monthly lacked documentation the services had been provided as indicated for the following dates in December: -ambulation/exercise daily in a.m. (6) -behavior irritability daily a.m., p.m., and bedtime (2, 9, 11, 12, 13) -clothing assist daily a.m. and p.m. (6, 9, 11, 12, 13) -record blood pressure, pulse, temperature, weight a.m. 1st Sunday (5) -report pain daily a.m. and p.m. (6, 8, 9, 10, 11, 12, 15, 18, 19, 22, 25, 26) -safety checks daily a.m., midday, overnight (2, 6, 8, 10, 11, 12, 13, 15, 18, 19, 23, 25 26) -serve and deliver meal to resident midday and p.m. (6, 8, 10, 11, 12, 13, 15, 19, 23, 25, 26) -bathing daily p.m. (6, 8, 9, 11, 12, 13) -care of personal possession daily p.m. (6, 9, 11, 12) -meal assistance daily p.m. (19, 20, 22, 23, 25, 26) -skin care (observe skin weekly) Wed. p.m. (8, 15, 22) In addition, there was no documentation indicating the resident had refused the services. On December 29, 2021, at 11:50 a.m. licensed	0 730		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 730	Continued From page 42 assisted living director (LALD)-B verified R1's record lacked documentation of services provided as noted above. A policy for documentation of services was requested, but not provided. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
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 and maintain the building physical environment, including walls, floors, and ceiling, in a continuous state of good repair and operation for health, comfort, and well-being of residents in accordance with a maintenance and repair program. This had the potential to affect all residents of the facility and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 800	Continued From page 43	0 800		

resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

On December 29, 2021, during a facility tour between 10:35 a.m. and 11:00 a.m. with licensed assisted living director (LALD)-A, the following was observed:

1. Bathroom #1 flooring was in bad condition with black staining around the entire perimeter. LALD-A stated he placed a work order with the landlord but had not heard back regarding the installation timeline. Sewer flies were observed in the sink and around the shower area. Dark staining was observed on the ceiling above the shower, this could be an indication of water damage or possible mold growth.

2. Bathroom #2 had broken towel rack supports projecting from the wall which could cause injury to residents or staff. LALD-A stated he placed a work order with the landlord but had not heard back regarding the installation timeline. Sewer flies were observed in the sink and around the shower area. Rusted and rotted drywall was observed outside the shower near the floor. This could be an indication of water damage. The exhaust fan was covered in dust and lint.

3. Bathroom #3 flooring was in bad condition with broken tiles around the toilet and sink areas. LALD-A stated he placed a work order with the landlord but had not heard back regarding the installation timeline. A hole in the wall was observed opposite the toilet. Disintegrating

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	27053	A. BUILDING: _____ B. WING _____	12/30/2021

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0 800	Continued From page 44 drywall and base were observed outside the shower. This could be an indication of water damage. The sealant joint at the bottom bathtub was damaged or missing along the floor joint. 4. Bedroom #6 and #7 flooring was damaged at the door threshold. Carpet fibers and strands were missing or exposed and have the potential to be a tripping hazard. LALD-A stated he placed a work order with the landlord but had not heard back regarding the installation timeline. The licensee lacked documentation for a maintenance plan or schedule for repairs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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	0 810		

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0 810	Continued From page 45 plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain fire safety and evacuation plans, failed to provide required training to residents and employees for fire safety and evacuation, and failed to conduct required employee evacuation drills. This had the potential to affect all current residents, staff, and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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:	0 810		

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0 810	Continued From page 46 On December 29, 2021, at approximately 11:00 a.m. the surveyor requested to review the licensee's fire safety and evacuation policy, plans, procedures, schedules, and logs, if available. Upon review the following items were not documented: 1. No evacuation plan or documentation on specific procedures for the residents including procedures for their movements, and relocation during a fire or similar, and no written instructions for addressing any unique situation during evacuation especially for residents who are wheelchair-bound and need assistance during an evacuation. 2. No record of required employee evacuation drills. Licensed assisted living director (LALD)-A stated they had not done any evacuation drills since August 2021. 3. No schedule or records on the training of employees on fire safety and evacuation; on proper actions to take in the event of a fire or emergency for the safety of residents including movement, evacuation, or relocation. 4. No schedule or records on the training of residents who are capable of assisting in their evacuation; on proper actions to take in the event of a fire or emergency for their safety including movement, evacuation, or relocation. 5. No fire safety and evacuation plan that showed the location and number of resident rooms. LALD-A confirmed documentation of fire safety and evacuation policy and procedures were incomplete.	0 810		

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0 810	Continued From page 47 No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any	0 900		

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0 900	Continued From page 48 additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written contract prior to providing assisted living services for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 began receiving assisted living services on August 1, 2021. R1's Admission and Service Plan Agreement dated July 18, 2019, indicated the basic services offered to all residents included, but were not limited to, medication management services ("RN" (registered nurse) medication need assessment, administration, set-up, monitoring, reminders and ordering). R1's Individualized Medication Service Plan dated July 18, 2021, included for the "Type of service," but not limited to, "Medication set up, Medication reminders, Medication administration," but it did not indicate what specific service for medication assistance R1 was receiving.	0 900		

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0 900	Continued From page 49 On December 28, 2021, at 11:42 a.m. unlicensed personnel (ULP)-C was observed to administer medications to R1. R1's record lacked an assisted living contract. On December 28, 2021, at 9:34 a.m. licensed assisted living director (LALD)-A stated, "I do not know what that is" in regards to an assisted living contract. LALD-A stated the licensee had not developed an assisted living contract for the licensee residents. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
01040 SS=D	144G.52 Subd. 7 Notice of contract termination required (a) A facility terminating a contract must issue a written notice of termination according to this section. The facility must also send a copy of the termination notice to the Office of Ombudsman for Long-Term Care and, for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, to the resident's case manager, as soon as practicable after providing notice to the resident. A facility may terminate an assisted living contract only as permitted under subdivisions 3, 4, and 5. (b) A facility terminating a contract under	01040		

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01040	Continued From page 50 subdivision 3 or 4 must provide a written termination notice at least 30 days before the effective date of the termination to the resident, legal representative, and designated representative. (c) A facility terminating a contract under subdivision 5 must provide a written termination notice at least 15 days before the effective date of the termination to the resident, legal representative, and designated representative. (d) If a resident moves out of a facility or cancels services received from the facility, nothing in this section prohibits a facility from enforcing against the resident any notice periods with which the resident must comply under the assisted living contract. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a copy of the termination notice to the Office of Ombudsman for Long-Term Care for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included depressive disorder, bipolar disorder and post cerebral vascular accident (CVA).	01040		

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01040	Continued From page 51 On December 28, 2021, at 11:42 a.m. unlicensed personnel (ULP)-C was observed to administer medications to R1. R1's Resident Notes dated November 5, 2021, indicated the case worker was notified of the alleged drug use and sale activity R1 was conducting in the house. It was determined R1 was taking advantage of other vulnerable residents by selling illegal drugs to them. "Resident was given a 30 day calendar day notice for the termination of his services and discharge. The notice was served to the CADI [community alternatives for disabled individuals] case worker". R1's Termination Notice was dated November 5, 2021, and indicated the notice was "consistent with a 30-calendar day notice pursuant to Rule 144A of home care services for the State of Minnesota regarding issuance of termination of service notice." The effective date of termination was December 5, 2021. On December 29, 2021, at 11:50 a.m. licensed assisted living director (LALD)-A and LALD-B stated they were not aware of the requirement of having to notify the Office of Ombudsman for Long-Term Care of termination of services for R1. A policy for notification of contract termination was requested, but not provided. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. TIME PERIOD FOR CORRECTION: Seven (7) days	01040		

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01370	Continued From page 52	01370		
01370 SS=E	144G.61 Subd. 2 Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27053	A. BUILDING: _____ B. WING _____	12/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01370	Continued From page 53 emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure competency evaluations were completed as required prior to providing direct care for two of two unlicensed personnel (ULP-C, ULP-D) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-C had a hire date of November 26, 2021. On December 28, 2021, at 11:42 a.m. ULP-C was observed to administer medications to R1. ULP-C's Comprehensive Home Care Regulatory Compliance Checklist for New Home Care Employees indicated "all required background checks and screenings, orientation and initial training or competency determination have been completed" and date successfully completed was December 8 and 9, 2021, for the following topics: -appropriate and safe techniques in personal hygiene and grooming, including:	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27053	A. BUILDING: _____ B. WING _____	12/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01370	Continued From page 54 -hair care and bathing -care of teeth, gums, and oral prosthetic devices -care and use of hearing aids -dressing and assisting with toileting; and -standby assistance techniques and how to perform them However, the checklist lacked evidence of a written procedure and indication of pass or fail for competency evaluations of the above topics. ULP-D had a hire date of June 23, 2017. ULP-D's Comprehensive Home Care Regulatory Compliance Checklist for New Home Care Employees indicated "all required background checks and screenings, orientation and initial training or competency determination have been completed" and date successfully completed was June 29, 2017, for the following topics: -appropriate and safe techniques in personal hygiene and grooming, including: -hair care and bathing -care of teeth, gums, and oral prosthetic devices -care and use of hearing aids -dressing and assisting with toileting; and -standby assistance techniques and how to perform them However, the checklist lacked evidence of a written procedure and indication of pass or fail for competency evaluations of the above topics. On December 29, 2021, at 2:47 p.m. licensed assisted living director (LALD)-A and LALD-B verified ULP-C and ULP-D's employee records lacked a written procedure and indication of pass or fail for competency evaluations of the above topics.	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SUNSET HOMES ASSISTED LIVING	11237 11TH AVENUE NW ORONOCO, MN 55960

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01370	Continued From page 55 The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01370		
01380 SS=E	144G.61 Subd. 2 Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure competency evaluations were completed as required prior to providing direct care for two of two unlicensed personnel (ULP-C, ULP-D) with records reviewed.	01380		

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01380	Continued From page 56 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-C had a hire date of November 26, 2021. On December 28, 2021, at 11:42 a.m. ULP-C was observed to administer medications to R1. ULP-C's Comprehensive Home Care Regulatory Compliance Checklist for New Home Care Employees indicated "all required background checks and screenings, orientation and initial training or competency determination have been completed" and date successfully completed was December 8 and 9, 2021, for the following topics: -reading and recording temperature, pulse, and respirations of the resident; -safe transfer techniques and ambulation; and -range of motioning and positioning However, the checklist lacked evidence of a written procedure and indication of pass or fail for competency evaluations of the above topics. In addition, ULP-C's employee record indicated "Skills/Competency Test" for "Administration of Oral Medications from Dosage Stripped Package" with written procedure for the skill and "pass" results for return demonstration and observation for the dates of December 6, 7 and 8, 2021.	01380		

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

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01380	Continued From page 57 However, ULP-C's employee record lacked evidence of a written procedure and indication of pass or fail for competency evaluations for the following: -administering medications (nebulizer, all routes other than oral); and -treatments (catheter care) ULP-D had a hire date of June 23, 2017. ULP-D's Comprehensive Home Care Regulatory Compliance Checklist for New Home Care Employees indicated "all required background checks and screenings, orientation and initial training or competency determination have been completed" and date successfully completed was June 29, 2017, for the following topics: -reading and recording temperature, pulse, and respirations of the resident; -safe transfer techniques and ambulation; -range of motioning and positioning; and -administering medications and treatments as required (no specific routes of medication or specific treatments were listed for training provided) However, the checklist lacked evidence of a written procedure and indication of pass or fail for competency evaluations of the above topics, including all routes of medications and catheter care. On December 29, 2021, at 2:47 p.m. licensed assisted living director (LALD)-A and LALD-B verified the ULP-C and ULP-D's employee records lacked written procedure and indication of pass or fail for competency evaluations of the above topics. LALD-A and LALD-B verified ULP-C and ULP-D provided the above delegated	01380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01380	Continued From page 58 tasks for the licensee's residents. The licensee policy Delegation of Nursing Tasks, Treatments or Therapy Tasks dated February 25, 2020, indicated a RN may delegate nursing tasks or may delegate treatments or assign therapy tasks after the ULP had successfully completed the training and demonstrated competency to the RN the ability to completely follow the procedures for the client and possess the knowledge and skills consistent with the complexity of the tasks. The policy was not updated to address the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01380		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;	01470		

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01470	Continued From page 59 (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.	01470		

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01470	Continued From page 60 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for two of two unlicensed personnel (ULP-C, ULP-D) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), 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: ULP-C had a hire date of November 26, 2021. On December 28, 2021, at 11:42 a.m. ULP-C was observed to administer medications to R1. ULP-C's Comprehensive Home Care Regulatory Compliance Checklist for New Home Care Employees indicated "Orientation to Home Care (144A.4796, Sub. 2) date successfully completed was December 6 and 7, 2021, for the following topics: -an overview of home care law; -review of agency policies/procedures related to provision of services; -handling of emergencies use of emergency services; -compliance with and reporting maltreatment of vulnerable adults/minors; -home care bill of rights;	01470		

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01470	Continued From page 61 -handling of client complaints, reporting complaints, and reporting complaints to Office of Health Facility Complaints (OHFC) and common entry point (CEP); -services of Ombudsman for Long-Term Care, Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman, county-managed care advocates, or other relevant advocacy services; and -review of the types of home care services the employee will be providing and the provider's scope of licensure. ULP-C's checklist lacked documented evidence of orientation to assisted living regulations (144G.63, Sub. 2) effective August 1, 2021, for the following: -an overview of this chapter; -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; and -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. ULP-D had a hire date of June 23, 2017. ULP-D's Comprehensive Home Care Regulatory Compliance Checklist for New Home Care Employees indicated "Orientation to Home Care (144A.4796, Sub. 2) date successfully completed was December 29, 2017, for the following topics:	01470		

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01470	Continued From page 62 -an overview of home care law; -review of agency policies/procedures related to provision of services; -handling of emergencies use of emergency services; -compliance with and reporting maltreatment of vulnerable adults/minors; -home care bill of rights; -handling of client complaints, reporting complaints, and reporting complaints to Office of Health Facility Complaints (OHFC) and common entry point (CEP); -services of Ombudsman for Long-Term Care, Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman, county-managed care advocates, or other relevant advocacy services; and -review of the types of home care services the employee will be providing and the provider's scope of licensure ULP-C's employee record lacked documented evidence of orientation to assisted living regulations (144G.63, Sub. 2) effective August 1, 2021, for the following: -an overview of this chapter; -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -handling of emergencies and use of emergency services; -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -the principles of person-centered planning and	01470		

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01470	Continued From page 63 service delivery and how they apply to direct support services provided by the staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On December 29, 2021, at 2:47 p.m. licensed assisted living director (LALD)-A and LALD-B verified ULP-C and ULP-D's employee records lacked the above training for orientation to assisted living regulations (144G.63, Sub. 2) effective August 1, 2021, as required. In addition, they verified all employees would lack the same training. A policy for employee orientation was requested, but not provided. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		

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01480	Continued From page 64	01480		
01480 SS=F	144G.63 Subd. 3 Orientation to resident Staff providing assisted living services must be oriented specifically to each individual resident and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff providing assisted living services were oriented specifically to each individual resident and the services to be provided for two of two unlicensed personnel (ULP-C, ULP-D) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), 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: ULP-C had a hire date of November 26, 2021. On December 28, 2021, at 11:42 a.m. ULP-C was observed to administer medications to R1. ULP-C's employee record lacked documentation of orientation to each individual resident and their needs prior to providing services. ULP-D had a hire date of June 23, 2017.	01480		

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01480	Continued From page 65 ULP-D's employee record lacked documentation of orientation to each individual resident and their needs prior to providing services. On December 29, 2021 at 2:47 p.m. licensed assisted living director (LALD)-A and LALD-B verified ULP-C and ULP-D's employee records lacked documentation of orientation to each individual resident and their needs prior to providing services. LALD-A stated he did not have employees document for orientation to each individual resident and their needs prior to providing services. A policy for orientation to resident was requested, but not provided. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01480		
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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SUNSET HOMES ASSISTED LIVING	11237 11TH AVENUE NW ORONOCO, MN 55960

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01500	Continued From page 66 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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01500	Continued From page 67 (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 two employees (unlicensed personnel (ULP)-D) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 had a hire date of June 23, 2017. ULP-D's employee record lacked evidence of documented annual training for the following required topics: -review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective	01500		

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01500	Continued From page 68 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; -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; -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On December 29, 2021, at 2:47 p.m. licensed assisted living director (LALD)-A and LALD-B verified ULP-D's employee record lacked evidence of annual training for the required topics above. A policy for employee annual training was requested, but not provided. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED	01530		

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01530	Continued From page 69 (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure two of two unlicensed personnel (ULP-C, ULP-D) received the required amount of dementia care training with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01530		

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01530	Continued From page 70	01530		

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-C
ULP-C had a hire date of November 26, 2021. ULP-C provided direct care and services to the licensee's residents.

On December 28, 2021, at 11:42 a.m. ULP-C was observed to administer medications to R1.

ULP-C's record identified training for dementia topics completed were dated December 28, 2021, for a total of six hours.

ULP-C's employee record lacked evidence of at least eight hours of initial training on topics required and a total of eight hours within 160 working hours of ULP-C's employment start date as required.

On December 29, 2021, at 2:47 p.m. licensed assisted living director (LALD)-A stated ULP-C started working with residents on December 6, 2021.

On December 30, 2021, at 8:58 a.m. LALD-A stated ULP-C had worked 199 hours as of December 27, 2021. LALD-A confirmed ULP-C lacked eight hours of initial dementia training on topics as required within 160 working hours of ULP-C's hire date November 26, 2021.

ULP-D
ULP-D had a hire date of June 23, 2017. ULP-D

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01530	Continued From page 71 provided direct care and services to the licensee's residents. ULP-D's employee record lacked evidence of two hours of training on topics related to dementia for each 12 months of employment as required. On December 29, 2021, at 2:47 p.m. LALD-A and LALD-B verified ULP-D's employee record lacked evidence of two hours of annual training for each 12 months of employment as required. The licensee's policy Dementia Training and Disclosure Requirements dated February 25, 2020, indicated the licensee provided the required dementia training to all direct care staff and their supervisors. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	01530		
01620 SS=D	144G.70 Subd. 2 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	01620		

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01620	Continued From page 72 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 observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing client monitoring and reassessment, not to exceed 90 calendar days from the last date of the assessment, and failed to ensure the RN completed a comprehensive reassessment to include all areas identified on the uniform assessment tool (UDALSA) for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), 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:	01620		

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01620	Continued From page 73 R1's diagnoses included depressive disorder, bipolar disorder and post cerebral vascular accident (CVA). On December 28, 2021, at 11:42 a.m. unlicensed personnel (ULP)-C was observed to administer medications to R1. R1's record indicated the assessments by the RN were completed as follows: -March 2, 2021; -June 25, 2021 (115 calendar days from the last date of assessment); and -September 28, 2021 (95 calendar days from the last date of assessment) In addition, R1's assessment dated September 28, 2021, lacked comprehensive assessment for all required areas on the UDALSA per requirement of the new Assisted Living Licensure regulations, effective August 1, 2021. On December 29, 2021, at 11:13 a.m. licensed assisted living director (LALD)-B verified R1's ongoing client monitoring and reassessments for 90 days were not completed within the time frame required. LALD-B stated she was "not aware of the UDALSA" tool. LALD-B verified R1's assessment dated September 28, 2021, contained some of, but not all areas of the UDALSA. The licensee policy Initial and On Going Nursing Assessment of Clients dated February 25, 2020, indicated the RN would reassess the client and update the service plan based on the resident's needs and at a frequency not to exceed 90 days from the last date of the assessment. The licensee lacked policies to include the new	01620		

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01620	Continued From page 74 Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	144G.70 Subd. 4 Service plan, implementation, and revisions t (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to finalize a current written service plan within 14 calendar days for	01640		

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01640	Continued From page 75 one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's record lacked a finalized service plan no later than 14 calendar days after the date that services were first provided. R1's record indicated R1 was admitted to the facility on July 18, 2019. R1's diagnoses included depressive disorder, bipolar disorder and post cerebral vascular accident (CVA). On December 28, 2021, at 11:42 a.m. unlicensed personnel (ULP)-C was observed to administer medications to R1. R1's Service Chart Monthly dated December 2021, indicated the services provided included: medication assist, activity assist, ambulation/exercises, appointment reminder assist, behavior irritability, care for personal possession assist, clothing assist, dressing a.m. and p.m., grooming, meal assistance, meal tray, record blood pressure 1st Sunday, record pulse 1st Sunday, record temperature 1st Sunday, record weight 1st Sunday, report pain, safety check, shopping assist, transportation assist,	01640		

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01640	Continued From page 76 bathing, laundry and skin care. R1's Admission and Service Plan Agreement dated July 18, 2019, read: "Upon completion of each assessment, an individualized service plan will be completed by RN. This plan will list services that will be provided to you and your signature, or that of your client representative /legal representative, will indicate your agreement to receive and pay for those services..." However, no individualized service plan was provided for R1 as indicated above. On December 29, 2021, at 11:50 a.m. licensed assisted living director (LALD)-B verified R1's record lacked an individualized service plan. The licensee policy Admission Process For New Clients dated February 20, 2021, indicated procedure for admission included, but not limited to, a "Home Care Agreement", which the RN explains and assists the client and/or client representative in completing and signing and "Service Plan" which indicated "Upon completion of the initial individualized nursing assessment, the RN develops a service plan with the client and/or client's representative no more than 14 days after the initiation of home care services. The RN and the client and/or the client's representative sign the service plan, and the RN gives a copy of the service plan to the client and/or the client's representative". The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided.	01640		

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01640	Continued From page 77 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01650 SS=D	144G.70 Subd. 4 Service plan, implementation, and revisions t (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service	01650		

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plan included all required content for one of one resident (R1) with record reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R1's diagnoses included depressive disorder, bipolar disorder and post cerebral vascular accident (CVA).

On December 28, 2021, at 11:42 a.m. unlicensed personnel (ULP)-C was observed to administer medications to R1. R1 was observed to have a plastic brace on his left lower leg.

R1's Service Chart Monthly dated December 2021, included: medication assist, activity assist, ambulation/exercises, appointment reminder assist, behavior irritability, care for personal possession assist, clothing assist, dressing a.m. and p.m., grooming, meal assistance, meal tray, record blood pressure 1st Sunday, record pulse 1st Sunday, record temperature 1st Sunday, record weight 1st Sunday, report pain, safety check, shopping assist, transportation assist, bathing, laundry and skin care.

R1's Admission and Service Plan Agreement dated July 18, 2019, indicated the following:
-basic services offered to all residents included, but not limited to, medication management

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services ("RN" (registered nurse) medication need assessment, administration, set-up, monitoring, reminders and ordering), meal service (preparation, set-up and monitoring for choking), laundry services, non-medical support services (shopping, community access), socialization activities, housekeeping services, mental health management services (orientation, wondering, anxiety, behavior, cognitive needs, agitation, etc.) assistance with activities of daily living (dressing, grooming, continence care, positioning, bathing, walking, wheeling, transferring, etc.) clinical monitoring services (INR [international normalized ratio] lab results for blood clotting), blood pressure, blood sugar, insulin administration, etc.), on site staff 24/7 days, call system device for each resident to use in summoning help from staff when need. All other services are personalized and will depend on the RN assessment.
-As required by law, the RN will complete your assessment before we can provide services to you. There is no fee for this assessment.
-Upon completion of RN initial assessment, your service needs will be determined. The RN will do reassessment on the "5th day, 14th day and 90th day". The RN will conduct further assessments as needed in case you have a change in your medical condition.
-"Upon completion of each assessment, an individualized service plan will be completed by RN. This plan will list services that will be provided to you and your signature, or that of your client representative /legal representative, will indicate your agreement to receive and pay for those services..."

The Admission and Service Plan Agreement further addressed advance directives, but it did not indicate if R1 had an advance directive or not,

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01650	Continued From page 80 911 would be summoned for emergency medical service, R1 was "Full Resuscitation" and a contingency plan that addressed the action to be taken if the scheduled service could not be provided and information and a method to contact the facility. R1's record included a sheet of paper signed by R1 on July 18, 2019, which indicated "I have not executed a Health Care Directive". However, no individualized service plan was provided for R1 as indicated above. R1's record lacked a service plan for the following: -a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; -the identification of staff or categories of staff who will provide the services; -the schedule and methods of monitoring assessments of the resident; -the schedule and methods of monitoring staff providing services; and -a contingency plan that included: - the action to be taken if the scheduled service cannot be provided; - information and a method to contact the facility; - the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and - the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.	01650		

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	27053	A. BUILDING: _____ B. WING _____	12/30/2021

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

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01650	Continued From page 81 On December 29, 2021, at 11:50 a.m. licensed assisted living director (LALD)-B verified R1's record lacked an individualized service plan. The licensee's policy Content of Service Plans dated February 25, 2020, indicated the licensee would have an up-to-date service plan identifying services to be provided based on the assessment by the RN. The service plan would contain all required information and would be signed by the RN, the resident and/or the resident representative. The policy was in reference to "Home Care Law MN Statute 144.44. 144A.4791, Subd. 6 and 9, 144A.44, Subd. 7, 144A.479, Subd. 3(6)". The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include	01700		

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01700	Continued From page 82 an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted an individualized assessment to determine what medication management services would be provided, and how the services would be provided for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01700		

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01700	Continued From page 83 R1's diagnoses included depressive disorder, bipolar disorder and post cerebral vascular accident (CVA). On December 28, 2021, at 11:42 a.m. unlicensed personnel (ULP)-C was observed to administer medications to R1. R1's Individualized Medication Service Plan dated July 18, 2019, indicated "caregivers administer medications as instructed, follow the procedure and document on MAR [medication administration record] as given/refused". R1's Review Form and Assessment for Medication Management Services was undated and unsigned by person who completed and listed medications with the following content: medication name, dosage, frequency, route, reason for medication, prescriber name, date prescribed, expiration date and reported side effects. The list included one medication used to help relax muscles in your body, two used to treat depression, one used to treat neuropathic pain, one used to reduce stomach acid, one used to treat high cholesterol, one used to promote sleep, one vitamin supplement and one used for urinary retention. R1's record included a prescriber's order dated July 1, 2021, for duloxetine (Cymbalta) (antidepressant) 60 milligrams (mg) one capsule two times a day. R1's record lacked current prescriber orders for any other medications. R1's MAR for December 2021, indicated R1 received one medication for muscle spasms, two for depression, one for neuropathy, one to reduce stomach acid, one vitamin supplement, one to lower cholesterol and one for sleep.	01700		

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01700	Continued From page 84 R1's record lacked an assessment to determine what medication management services would be provided and how the services would be provided prior to providing medication management services by the RN, to include the following: -documentation the assessment was conducted face-to-face with the resident; -identification and review of all medications the resident is known to be taking, which included indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues; -identification of interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications On December 29, 2021, at 11:13 a.m. licensed assisted living director (LALD)-B verified R1's record lacked a medication assessment for the above content prior to providing medication management services. The licensee policy Initial and Ongoing Nursing Assessment of Clients dated February 25, 2020, indicated the assessment for the client's need for medication management services would be face to face and would include the above content as required. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided.	01700		

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01700	Continued From page 85 TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to monitor and reassess the resident's medication management services at least annually for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included depressive disorder, bipolar disorder and post cerebral vascular accident (CVA). On December 28, 2021, at 11:42 a.m. unlicensed	01710		

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01710	Continued From page 86 personnel (ULP)-C was observed to administer medications to R1. R1's Individualized Medication Service Plan dated July 18, 2019, indicated "caregivers administer medications as instructed, follow the procedure and document on MAR [medication administration record] as given/refused". R1's Review Form and Assessment for Medication Management Services was undated and unsigned by the person who completed and listed medications with the following content: medication name, dosage, frequency, route, reason for medication, prescriber name, date prescribed, expiration date and reported side effects. The list included one medication used to help relax muscles in your body, two used to treat depression, one used to treat neuropathic pain, one used to reduce stomach acid, one used to treat high cholesterol, one used to promote sleep, one vitamin supplement and one used for urinary retention. R1's record included a prescriber's order dated July 1, 2021, for duloxetine (Cymbalta) (antidepressant) 60 milligrams (mg) one capsule two times a day. R1's record lacked current prescriber orders for any other medications. R1's MAR for December 2021, indicated R1 received one medication for muscle spasms, two for depression, one for neuropathy, one to reduce stomach acid, one vitamin supplement, one to lower cholesterol and one for sleep. R1's record lacked monitoring and reassessment of medication management services at least annually for the following: - documentation the assessment was conducted	01710		

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01710	Continued From page 87 face-to-face with the resident; - identification and review of all medications the resident is known to be taking, which included indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues; - identification of interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications On December 29, 2021, at 11:13 a.m. licensed assisted living director (LALD)-B verified R1's record lacked monitor and reassessment of medication management services annually as required for the above content. The licensee policy Initial and Ongoing Nursing Assessment of Clients dated February 25, 2020, indicated the assessment for the resident's need for medication management services would be face to face and would include the above content as required. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication	01760		

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01760	Continued From page 88 Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medication was not administered as ordered for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee lacked discontinuation of pantropazole (used to reduce stomach acid) as prescribed. R1's Physician Telephone Orders dated August	01760		

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01760	Continued From page 89 14, 2019, indicated "discontinue pantoprazole" 40 milligrams (mg) as resident has been refusing to take for the last week and stated that he does not need this medication." On December 28, 2021, at 11:42 a.m. unlicensed personnel (ULP)-C was observed to administer pantoprazole 40 mg to R1. R1's medication administration record (MAR) for December 2021, identified R1 was receiving pantoprazole 40 mg by mouth one time a day. On December 29, 2021, at 11:13 a.m. licensed assisted living director (LALD)-B verified R1 was receiving pantoprazole and the medication was not discontinued as prescribed on August 14, 2019. The licensee's policy Content of Medication Prescriptions and Treatment or Therapy Orders dated February 25, 2020, indicated the RN was responsible for assuring changes in orders were addressed in the client's MAR. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01790 SS=E	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed	01790		

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01790	Continued From page 90	01790		

nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days;
(3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and
(4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled.
(b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if:
(1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and
(2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address:
(i) the type of container or containers to be used for the medications appropriate to the provider's medication system;
(ii) how the container or containers must be labeled;
(iii) written information about the medications to be provided;
(iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of

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01790	Continued From page 91	01790		

medications that were provided to the resident, and other required information;
(v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative;
(vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and
(vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to ensure competency evaluations were completed as required two of two unlicensed personnel (ULP-C, ULP-D) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

ULP-C had a hire date of November 26, 2021.

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01790	Continued From page 92 On December 28, 2021, at 11:42 a.m. ULP-C was observed to administer medications to R1. ULP-D had a hire date of June 23, 2017. ULP-C and ULP-D's records lacked evidence to indicate the registered nurse (RN) provided training and determined competency to prepare and administer medications to residents for unplanned times away. On December 29, 2021, at 2:47 p.m. licensed assisted living director (LALD)-A and LALD-B confirmed the licensee's ULP could prepare and send medications with the resident or the resident's responsible person, according to the licensee's policy and procedure. LALD-A and LALD-B verified ULP-C and ULP-D administered medications, but were not trained and had not demonstrated competency to prepare or give medications for any of the licensee's residents for unplanned times away. The licensee's policy Medication Planned and Unplanned Leave of Absence from the Facility dated February 25, 2020, indicated the RN may delegate this task to unlicensed staff if the RN had trained and determined the competency of the unlicensed staff on procedures to follow when giving medications to residents who would be away from the facility for no more than 120 hours. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01790		

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01790	Continued From page 93 days	01790		
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure prescriptions were renewed at least every 12 months for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's Individualized Medication Service Plan dated July 18, 2019, indicated "caregivers administer medications as instructed, follow the procedure and document on MAR [medication administration record] as given/refused". On December 28, 2021, at 11:42 a.m. unlicensed personnel (ULP)-C was observed to administer medications to R1.	01830		

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

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01830	Continued From page 94 R1's MAR for December 2021, indicated R1 received one medication for muscle spasms, two for depression, one for neuropathy, one to reduce stomach acid, one vitamin supplement, one to lower cholesterol and one for sleep. R1's record included a prescriber's order dated July 1, 2021, for duloxetine (Cymbalta) (used for depression) 60 milligrams (mg) one capsule two times a day, and identified the following prescriptions lacked renewal at least every 12 months as required: -dated July 23, 2019, Baclofen (used for muscle spasms) 10 mg three times a day and 20 mg at 5 p.m.; -dated July 23, 2019, Trazodone (used for sleep) 50 mg at bedtime; -dated July 23, 2019, vitamin D3 1,000 unit tablet daily; -dated July 23, 2019, rosuvastatin (used to lower cholesterol) 10 mg daily; -dated July 23, 2019, levetriacetam (used to treat depression) 500 mg two times a day; -dated September 24, 2019, tamsulosin (used for urinary retention) 0.4 mg daily as needed; and -dated September 27, 2019, gabapentin (used for neuropathy pain) 600 mg two tablets three times a day On December 29, 2021, at 11:13 a.m. licensed assisted living director (LALD)-B verified R1's record lacked renewal of the above prescriptions at least every 12 months. The licensee policy Content of Medication Prescriptions and Treatment or Therapy Orders dated February 25, 2020, indicated the RN would assure the prescriber renews a medication prescription order at least every 12 months.	01830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27053	A. BUILDING: _____ B. WING _____	12/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01830	Continued From page 95 The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
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 access to keys for a medication cart was secure. This had the potential to affect all six residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 28, 2021, at 11:45 a.m. unlicensed personnel (ULP)-C was observed to place the keys for the licensee's medication cart, where resident medications were stored, into an	01880		

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	27053	A. BUILDING: _____ B. WING _____	12/30/2021

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01880	Continued From page 96 unlocked drawer to the right of the kitchen sink. The drawer could be accessed by all residents and visitors. ULP-C verified the drawer was not secure and any person would have access to the keys for the medication cart. On December 28, 2021, at 12:19 p.m. licensed assisted living director (LALD)-A stated he had seen employees place the keys for the medication cart into the drawer. LALD-A verified the drawer had no lock and was unsecured for the keys to the medication cart to be stored in. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
02240 SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center	02240		

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02240	Continued From page 97 (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, e-mail, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents was provided to the resident and a written acknowledgement received for one of one residents (R1) with record reviewed. This had the potential to affect all residents.	02240		

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02240	Continued From page 98 This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 began receiving assisted living services on August 1, 2021. On December 28, 2021, at 11:42 a.m. unlicensed personnel (ULP)-C was observed to administer medications to R1. R1's record indicated on July 18, 2019, R1 had received a copy of the "Home Care Bill of Rights"; however, R1's record lacked evidence the resident had received the Assisted Living Bill of Rights dated May 16, 2021. On December 29, 2021, at 2:47 p.m. licensed assisted living director (LALD)-A confirmed the current residents did not have a signed acknowledgement of receiving the current Assisted Living Bill of Rights dated May 16, 2021. The licensee's policy Admission Process for New Clients dated February 25, 2020, indicated prior to the initiation of any home care service the registered nurse (RN) would ensure the Home Care Bill of Rights would be given in writing and explained to the client and/or the client's representative and would obtain written acknowledgement for receipt of the information. The licensee lacked policies to include the new	02240		

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02240	Continued From page 99 Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		
02260 SS=C	144G.90 Subd. 3 Notice of dementia training An assisted living facility with dementia care shall make available in written or electronic form, to residents and families or other persons who request it, a description of the training program and related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered. A hard copy of this notice must be provided upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who request it, a description of the dementia care training program, the categories of employees trained, the frequency of training, and the basic topics covered with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	02260		

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02260	Continued From page 100 The findings include: On December 29, 2021, at 10:00 a.m. licensed assisted living director (LALD)-A stated the licensee did not have the written disclosure to provide to residents, families or other persons who requested it. LALD-A verified the licensee would provide services to persons with dementia. The licensee's policy Dementia Training and Disclosure Requirements dated February 25, 2020, indicated the home care director would develop a written statement called the "Dementia Training Disclosure" that would be available in both hard copy and electronically to clients, the clients' representatives and families upon their request. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02260		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision.	03090		

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03090	Continued From page 101 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff and any visitors of the licensee. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 28, 2021, at approximately 9:10 a.m. upon arriving at the establishment, an observation outside the front entrance, or just inside the front entrance, lacked the required posting for electronic monitoring devices. On December 28, 2021, at 9:34 p.m. licensed assisted living director (LALD)-A verified the licensee had no posting at the facility entrance for electronic monitoring as required. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION:	03090		

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03090	Continued From page 102 Twenty-One (21) days	03090		

Minnesota Department of Health
Division of Envrionmental Health, FPLS
PO BOX 64975
St Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *12/28/21*
Time: 10:30:00
Report: 8040221002

Food and Beverage Establishment Inspection Report

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

Establishment Info:
ID #: N27053
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/22

Operator:

Joseph Mabururu
Phone #: 507-364-4438
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.

3-500B Microbial Control: hot and cold holding
3-501.16A2 ***** Priority 1 *****
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
KITCHEN UPRIGHT COOLER MILK MEASURED AT 45dF
Comply By: 12/28/21

4-700 Sanitizing Equipment and Utensils
4-703.11B ***** Priority 1 *****
MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.
DISHMACHINE MUST PROVIDE AT LEAST 160dF RINSE TEMPERATURE TO PROPERLY SANITIZE DISHES AND UTENSILS. SEE COMMENTS.
Comply By: 12/28/21

5-200B Plumbing: cross connections
5-203.14A ***** Priority 1 *****
MN Rule 4626.1085A Water used under pressure in equipment in food and beverage establishments must be drained to a sanitary sewer through an air gap. Examples: refrigeration cooling water, water softener, and drained steam jacketed kettles.
PROVIDE AN AIR GAP ON WATER SOFTENER DISCHARGE HOSE.
Comply By: 01/28/22

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

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

PROVIDE THERMAL-LABELS TO MEASURE RINSE TEMPERATURE OF DISHMACHINE.

Comply By: 01/28/22

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

ESTABLISHMENT MUST PROVIDE THE APPROPRIATE STRIPS TO MEASURE THE SANITIZER CHOSEN.

Comply By: 01/11/22

5-100 Water

5-102.13 ***** Priority 2 *****

MN Rule 4626.1005 Water from a public water system must be sampled and tested as required by chapter 4720, rules for public water supplies.

ESTABLISHMENT SERVED BY PRIVATE WELL. WELL MUST BE TESTED FOR COLIFORM BACTERIA AND NITRATES ANNUALLY. WATER SAMPLE REORTS MUST BE RETAINED ON FILE FOR ONSITE REVIEW UPON REQUEST.

Comply By: 03/28/22

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

PROVIDE THERMOMETER IN UPRIGHT COOLER, NEXT TO UPRIGHT FREEZER.

Comply By: 01/04/22

4-300 Equipment Numbers and Capacities

4-303.11B

MN Rule 4626.0721B Provide chemical sanitizers to sanitize equipment and utensils during all hours of operation.

FOOD CONTACT SURFACES OF EQUIPMENT AND COUNTERS MUST BE SANITIZED. NO SANITIZER ON SITE. PROVIDE CHLORINE OR QUATERNARY AMMONIA. FOLLOW MANUFACTURER INSTRUCTIONS FOR SANITIZING FOOD CONTACT SURFACES.

Comply By: 01/04/22

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

UPRIGHT FREEZER HANDLE LOOSE.

Comply By: 01/04/22

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

HANG HANDWASHING REMINDER SIGNS AT ALL HAND SINKS. INCLUDING RESTROOMS. SIGNS PROVIDED TO JOSEPH, RN-A.

Comply By: 01/04/22

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.16

MN Rule 4626.1540 Hang mops to dry after each use and do not store mops in a manner that will soil walls, equipment or supplies.

PROVIDE MOP HANGERS TO HANG MOPS TO DRY AFTER USE.

Comply By: 01/28/22

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 45 Degrees Fahrenheit - Location: MILK
Violation Issued: No

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

Process/Item: Cooking
Temperature: 198 Degrees Fahrenheit - Location: BAKED BEANS
Violation Issued: No

Process/Item: Cooking
Temperature: 211 Degrees Fahrenheit - Location: CHICKEN NUGGETS
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	3	3	5

INSPECTION CONDUCTED AS PART OF HRD ASSISTED LIVING SURVEY. DANETTE BAKKEN, HRD NURSING EVALUATOR PRESENT DURING INSPECTION.

FACILITY STAFF JOSEPH, RN-A AND TROKON ULP-C PRESENT DURING INSPECTION.

5102.13 DISCUSSED REQUIREMENT FOR NON-COMMUNITY PUBLIC WATER SUPPLY (PRIVATE WELL) TO BE TESTED ANNUALLY WITH JOSEPH, RN-A. OLMSTED COUNTY PUBLIC HEALTH PROVIDES WATER TESTING. A COMPLETE LIST OF ACCREDITED LABORATORIES CAN BE FOUND HERE:
https://www.health.state.mn.us/communities/environment/water/docs/wells/waterquality/labmap.pdf

4-703.11B DISCUSSED WITH JOSEPH, RN-A, HOT WATER REQUIREMENTS FOR THE DISHMACHINE TO PROPERLY SANITIZE. A RESIDENTIAL DISHMACHINE WITH AN NSF CERTIFIED SANITIZE CYCLE IS ONLY TESTED TO ACHIEVE 150dF. THERMAL-LABLELS ARE REQUIRED TO TEST HOT WATER TEMPERATURE TO ENSURE 160dF OR HIGHER IS MET. A SPERATE WATER HEATHER MAY BE NEEDED T OBSERVE THE KITCHEN TO ACHIEVE THE REQUIRED WATER TEMPERATURE.

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 8040221002 of 12/28/21.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/__/____

Signed:_____
JOSEPH, RN-A
RN/OWNER/ADMIN

Signed:_____
Matthew Finkenbiner
Sanitarian Supervisor
Rochester District Office
507-206-2744
matthew.finkenbiner@state.mn.us