DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered

August 3, 2026

Licensee
Sunrise Assisting Living LLC
7708 45th 1/2 Ave North
New Hope, MN 55428

RE: Provisional Conditional License Number 422355
Health Facility Identification Number (HFID) 41846
Project Number(s) SL41846015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 7, 2026, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.16, Subd. 3(b)(2), MDH is extending the provisional license for 60-days and applying conditions necessary to bring the facility into substantial compliance. The provisional license extension and conditions are due to expire **October 2, 2026**.

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

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

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

Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is $. **MDH is not imposing these fines against your provisional license at this time.**

0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $500.00
2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $1,000.00

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

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the provisional licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

The correction order documentation should include the following:

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

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

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

CONDITIONAL LICENSE ISSUED:
MDH will issue Sunrise Assisting Living LLC a conditional provisional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6.

Based on the results of the follow-up survey, MDH will determine if Sunrise Assisting Living LLC is in substantial compliance.

The following conditions apply on the conditional provisional assisted living facility license:

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional provisional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the provisional license.

b. **No new admissions:** Sunrise Assisting Living LLC will not admit any new residents under its conditional provisional assisted living facility license until MDH removes the "no new admissions" condition. Sunrise Assisting Living LLC must provide the Department:

   i. A list of the names and birthdates of any individuals Sunrise Assisting Living LLC is currently in the process of admitting. These individuals will be able to continue the admittance process.

   ii. A list of all current residents including:
      1. Name and birthdate of each resident
      2. Current payment source for services
      3. If Elderly Waiver, the name and contact information of the care coordinator/case manager
      4. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL PROVISIONAL LICENSE PERIOD:
MDH will determine if Sunrise Assisting Living LLC is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional provisional license period. If MDH determines Sunrise Assisting Living LLC is in substantial compliance on the follow up survey, MDH will remove the conditions and grant the assisted living facility license to Sunrise Assisting Living LLC. If MDH determines Sunrise Assisting Living LLC is not in substantial compliance, MDH may deny the license pursuant to Minn. Stat. § 144G.16, Subd. 3 (b) (2).

REQUEST FOR RECONSIDERATION:
Pursuant to Minn. Stat. §144G.16, Subd. 4, if a provisional licensee whose assisted living facility license has been denied, or extended with conditions, disagrees with the action taken against the provisional license under this section, the provisional licensee may request a reconsideration no later than 15 calendar days after provisional licensee receives notice of the action. **This is your only ability to request a reconsideration under this enforcement action.**

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

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

If you have any questions, please contact Casey DeVries directly at: 651-201-5917 or email at: casey.devries@state.mn.us.

Sincerely,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41846	A. BUILDING: _____ B. WING _____	07/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ASSISTING LIVING LLC	7708 45TH 1/2 AVE N NEW HOPE, MN 55428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL41846015-0 On July 6, 2026, through July 7, 2026, the Minnesota Department of Health conducted an initial survey at the above provider and the following correction orders are issued. At the time of the survey, there was one resident; one receiving services under the Provisional Assisted Living Facility license. An immediate correction order was identified on July 7, 2026, issued for SL41846015-0, tag identification 2310. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 6, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for one of three employees (unlicensed personnel (ULP-B). This practice resulted in a level two violation (a	0 650		

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0 650	Continued From page 4 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-B was hired on January 25, 2025, and began providing assisted living services. ULP-B's record included a certificate of completion for the Licensed Assisted Living Director (LALD) dated March 13, 2026, which indicated ULP-B had completed 124.5 contact hours. ULP-B's record lacked training and competency in the required 22 areas as required by Minnesota Statute 144G.61, Subd. 2. Although ULP-B had a certificate of completion to verify they completed 124.5 contact hours for the Assisted Living Director Program, Minnesota Rule Chapter 6400 indicated the course requirements, basic areas of study, and field experience for licensed assisted living directors pertained to customer care, human resources, finance, environment, management and leadership, person-centered care practices, vulnerable adult protection, Minnesota rules governing compliance, landlord-tenant law, role of the state ombudsman, elder care rights, practice acts for Minnesota health-related licensing boards, client and family relationships, and health and wellness topics. The course requirements did not include the above-mentioned missing training topics	0 650		

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0 650	Continued From page 5 related to direct care. On July 8, 2026, at 1:59 p.m., ULP-B stated they had completed training with the former clinical nurse supervisor (CNS). ULP-B stated they completed the following topics even though they could not remember all: medication training routes, transfers, resident safety, resident care plan, skin check, and showers. ULP-B also stated they returned demonstration to the CNS and that they had a checklist that they went through. On July 9, 2026, at 2:40 p.m., ULP/manager (ULP/M)-D stated ULP-B had completed training with former CNS, but they could not get those records. ULP/M-D also stated they had moved their cabinets and that maybe the record was in different folders. The licensee's Personnel Records policy dated December 1, 2025, indicated a record of each paid employee, regularly scheduled volunteer providing assisted living services, and each individual contractor providing assisted living services for [licensee] will be maintained. 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	0 660		

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0 660	Continued From page 6 and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included TB history and symptom screen, baseline screening, and TB training for three of three employees (clinical nurse supervisor (CNS)-A, unlicensed personnel/manager (ULP/M)-D, registered nurse (RN)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The facility TB risk assessment dated March 7, 2026, indicated the facility was at a low risk for TB	0 660		

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0 660	Continued From page 7 transmission. CNS-A CNS-A started employment with the licensee on June 2, 2026, to provide assisted living services. On July 7, 2026, at 9:00 a.m., the surveyor observed CNS-A working within the facility. ULP/M-D ULP/M-D started employment with the licensee on March 5, 2026, to provide assisted living services. On July 7, 2026, at 7:45 a.m., the surveyor observed ULP/M-D administer medications to R1 in their room. ULP/M-D's record included a chest Xray (CXR) dated March 18, 2026. ULP/M-D's CXR did not have any correlation with a positive TB test prior. RN-E RN-E started employment with the licensee on March 5, 2026, to provide assisted living services as a backup nurse. R1's 14-day nursing reassessment was completed by RN-E. CNS-A, ULP/M-D, and RN-E's record lacked TB history and symptom screen, baseline screening, and TB training. On July 8, 2026, at 2:50 p.m., ULP/M-D stated they were not aware they needed to complete TB history and symptom screen, baseline screening, and TB training. CNS-A and RN-E were not available for interview.	0 660		

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0 660	Continued From page 8 The licensee's Tuberculosis Screening/Prevention dated December 1, 2025, indicated [licensee] will observe the recommended precautions related to TB prevention as identified by the Centers for Disease Control and Prevention (CDC) and the Minnesota Department of Health (MDH). The precautions include the following elements: - risk assessment - TB screening - staff education The Minnesota Department of Health's Assisted Living FAQs: Staff Requirements dated June 5, 2026, indicated baseline TB screening is required at the time of hire for all health care personnel in Minnesota. The FAQs indicated baseline TB screening includes assessing for current symptoms of active TB disease, assessing TB history, and testing for the presence of Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or single TB blood test. The FAQs further indicated all Minnesota health care personnel should receive TB education annually, regardless of facility risk level classification. The FAQs also indicated A CXR alone is not acceptable documentation. You either need documentation of a positive two-step Tuberculin Skin Test (TST) or Interferon-Gamma Release Assay (IGRA) test, and a CXR with provider evaluation after that date or documentation of refusal of both the two-step TST and IGRA followed by a new CXR and provider evaluation, or documentation of refusal of both the two-step TST and IGRA followed by a new CXR and provider evaluation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 660		

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0 660	Continued From page 9 (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors.	0 680		

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0 680	Continued From page 10 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's emergency preparedness plan dated March 3, 2026, lacked evidence of the following required content: - EPP program patient population; - subsistence needs for staff and patients; - policies and procedures for medical documents; - policies and procedures for volunteers; - development of communication plan; - primary/alternate means for communication; - methods for sharing information; - sharing information on occupancy/needs; and - LTC family notifications. On July 8, 2026, at 2:00 p.m., unlicensed personnel/manager (ULP/M)-D stated they had reviewed their EPP and thought it was complete with all required content. The licensee's Emergency Management policy dated October 23, 2024, indicated the licensee would have an identified plan in place to ensure the safety and well-being of residents and employees during periods of an emergency or a disaster that disrupts facility services. Minnesota Administrative Rule 4659.0100 Emergency Disaster and Preparedness Plan dated August 11, 2021, indicated assisted living	0 680		

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	41846	A. BUILDING: _____ B. WING _____	07/07/2026

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0 680	Continued From page 11 facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. The code references documents, specifications, methods, and standards in the State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=C	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing	0 780		

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0 780	Continued From page 12 buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level one violation (a violation that will cause only 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 the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated July 7, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=B	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds,	0 800		

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0 800	Continued From page 13 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, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated July 7, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) days	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) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in	0 810		

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0 810	Continued From page 15 compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated July 7, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
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);	01470		

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01470	Continued From page 16 (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 staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual	01470		

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01470	Continued From page 17 and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees completed required orientation training prior to providing services, for one of three employees (clinical nurse supervisor (CNS)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: CNS-A started employment with the licensee on June 2, 2026, to provide assisted living services and clinical oversight. On July 7, 2026, at 9:00 a.m., the surveyor observed CNS-A working within the facility. CNS-A's My Transcript indicated CNS-A had completed orientation training on various dates as follows: - handling emergencies and using emergency services - January 30, 2026; - reporting maltreatment of vulnerable adults or minors - January 22, 2026;	01470		

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01470	Continued From page 18 - Assisted Living Bill of Rights - May 16, 2026; and - principles of person-centered planning/service delivery - January 23, 2026. CNS-A's record lacked documentation of the following required orientation: - overview of Assisted Living statutes; - review of provider's policies and procedures; - handling of resident complaints, reporting of complaints, where to report; - consumer advocacy services; and - review of types of Assisted Living services the employee will provide and provider's scope of license. On July 8, 2026, at 2:30 p.m., unlicensed personnel/manager (ULP/M)-D stated CNS-A had completed orientation training at another licensee not under the same ownership as the current licensee. The licensee's Staff Orientation and Education policy dated December 1, 2025, indicated all staff providing assisted living through [licensee] will be prepared to provide safe, effective services to all residents through a thorough orientation and education program pertinent to the needs of the residents. The policy also indicated the missing orientation training topics will be included. Minnesota Statutes 144G.63 Subd 1(a) and (b) indicated the orientation need only be completed once for each staff person and is not transferable to another facility, except if the staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of the first facility.	01470		

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01470	Continued From page 19 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01530 SS=E	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the	01530		

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01530	Continued From page 20 requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure eight hours of initial dementia training and two hours of initial mental illness and de-escalation training was conducted within 160 hours of providing direct care to residents for two of four employees (unlicensed personnel/manager (ULP/M)-D, registered nurse (RN)-E). 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/M-D ULP/M-D started employment with the licensee on March 5, 2026, to provide assisted living services. ULP/M-D's record included tests that were	01530		

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01530	Continued From page 21 graded with a "pass" dated March 14, 2026, in the following topics: - an explanation of Alzheimer's and other dementias; - assistance with activities of daily living (ADL); - problem solving challenging behaviors; - communication skills; - person-centered planning and service delivery; and - mental illness and de-escalation. RN-E RN-E started employment with the licensee on March 5, 2026, to provide assisted living services. RN-E's record included undated tests that were graded with a "pass" in the following topics: - an explanation of Alzheimer's and other dementias; - assistance with activities of daily living (ADL); - problem solving challenging behaviors; - communication skills; - person-centered planning and service delivery; and - mental illness and de-escalation. ULP/M-D and RN-E's record did not include the number of hours for each dementia training completed up to eight hours of dementia and two hours of mental illness. On July 8, 2026, at 2:45 p.m., ULP/M-D stated they did not know they were required to include the number of hours for each dementia and mental illness training completed. The licensee's Dementia Education policy dated December 1, 2025, indicated all staff providing care at [licensee] will be knowledgeable in how to provide safe, effective services related to	01530		

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01530	Continued From page 22 dementia. The policy also included direct-care employees must have completed at least eight (8) hours of initial education within 160 working hours of the employment start date and supervisors of direct-care staff will have at least eight (8) hours of initial education within 120 working hours of employment start date. The policy lacked a verbiage to include training in mental illness. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01610		

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01610	Continued From page 23 licensee failed to ensure the registered nurse (RN) completed an initial comprehensive nursing assessment on, or before, the date of admission for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on March 3, 2026, and began receiving assisted living services. R1's Service Plan dated March 6, 2026, indicated R1 received assistance with home health aide services, resident assessments, supervision of staff, assistance with dressing, assistance with grooming, toileting, mobility/safety, bed rail for repositioning, and fall prevention, assistance with meals, medication administration, homemaker, and vital signs. R1's Admission Assessment dated March 6, 2026, was completed three days after R1 was admitted. On July 8, 2026, at 2:45 p.m., unlicensed personnel/manager (ULP/M)-D stated they were aware the assessment was completed late. ULP/M-D stated they had difficulty getting hold of their previous CNS to come complete the assessment on the day R1 was admitted.	01610		

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01610	Continued From page 24 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41846	A. BUILDING: _____ B. WING _____	07/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ASSISTING LIVING LLC	7708 45TH 1/2 AVE N NEW HOPE, MN 55428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01730	Continued From page 25 documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to accurately maintain an individualized medication management plan (IMMP) to include all required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on March 3, 2026, and began receiving assisted living services. R1's Service Plan dated March 6, 2026, indicated R1 received assistance with home health aide	01730		

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	41846	A. BUILDING: _____ B. WING _____	07/07/2026

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SUNRISE ASSISTING LIVING LLC	7708 45TH 1/2 AVE N NEW HOPE, MN 55428

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01730	Continued From page 26 services, resident assessments, supervision of staff, assistance with dressing, assistance with grooming, toileting, mobility/safety, bed rail for repositioning, and fall prevention, assistance with meals, medication administration, homemaker, and vital signs. On July 7, 2026, at 7:45 a.m., the surveyor observed unlicensed personnel/manager (ULP/M)-D administer medications to R1 in their room. R1's record lacked content for IMMP to include the following: - type of medication storage system, based on resident's needs; - person responsible for monitoring medication supplies and refills; and - procedures for staff to notify an RN when problems arose. On July 8, 2026, at 2:50 p.m., ULP/M-D stated they were not sure if CNS-A had the knowledge of R1's IMMP. The surveyor called CNS-A's phone and left a voicemail to call back; however CNS-A did not call. The licensee's Service Plan for Medication Management policy dated December 1, 2025, indicated [licensee] will prepare and document a Medication Management Plan as part of the service plan for each resident receiving medication management services. The policy also indicated IMMP will include all the missing content above. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		

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	41846	A. BUILDING: _____ B. WING _____	07/07/2026

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01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation for medication administration included the signature and title of the person who administered medications for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on March 3,	01760		

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SUNRISE ASSISTING LIVING LLC	7708 45TH 1/2 AVE N NEW HOPE, MN 55428

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01760	Continued From page 28 2026, and began receiving assisted living services. R1's Service Plan dated March 6, 2026, indicated R1 received assistance with home health aide services, resident assessments, supervision of staff, assistance with dressing, assistance with grooming, toileting, mobility/safety, bed rail for repositioning, and fall prevention, assistance with meals, medication administration, homemaker, and vital signs. On July 7, 2026, at 7:45 a.m., the surveyor observed unlicensed personnel/manager (ULP/M)-D administer medications to R1 in their room. R1's Medication Administration Record (MAR) dated June 1, 2026, through June 30, 2026, indicated R1 received the following medications: albuterol sulfate 2.5 milligram (mg)/3 milliliter (ml) take one nebulizer twice daily, allopurinol 300 mg take one tablet by mouth once daily, amlodipine besylate take one tablet (5 mg) by mouth daily, atorvastatin calcium take one tablet (40 mg) by mouth at bedtime, cetirizine hcl take l tablet (10 mg) by mouth once daily, ciclopirox olamine (cream) apply topically to affected area(s) twice daily, omeprazole (Prilosec) take one capsule (20 mg) by mouth once daily before a meal, hydrochlorothiazide 25 mg take one tablet (25 mg) by mouth once daily, lisinopril 40 mg take one tablet (40 mg) by mouth once daily, and levothyroxine sodium 150 microgram (mcg) take one tablet (l 50 mcg) by mouth before breakfast. R1's MAR indicated medications administered were documented by initials and lacked the corresponding signatures and title of the persons who completed the administration.	01760		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01760	Continued From page 29 On July 8, 2026, at 2:45 p.m., ULP/M-D stated they were trained to document in the MAR using their initials, and that all staff at the last page of the MAR are supposed to sign and indicate their titles. ULP/M-D further stated CNS-A was responsible for ensuring accurate documentation of medication administration however, CNS-A was not available to respond. The licensee's Medication Documentation policy dated December 1, 2025, indicated medication administered will be documented in the resident's clinical record. Documentation will be complete, accurate and legible. The policy also indicated complete documentation of medication administration includes the following: a. resident's name b. medication name c. medication dosage d. date and time of administration e. method/route of administration f. signature and Title of staff administering the medication No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.	02310		

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02310	Continued From page 30 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of one resident (R1) with hospital bed rails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on March 3, 2026, for assisted living services. R1's diagnoses included hypertension, prediabetes, stage 3 chronic kidney disease, right arm weakness, and peripheral artery disease (PAD). R1's Service Plan dated March 6, 2026, indicated R1 received assistance with home health aide services, resident assessments, supervision of staff, assistance with dressing, assistance with grooming, toileting, mobility/safety, bed rail for repositioning, and fall prevention, assistance with meals, medication administration, homemaker, and vital signs. On July 6, 2026, at 11:02 a.m., during the facility tour the surveyor observed R1's hospital bed had bilateral bed rails measuring approximately 3 feet long by 2 feet wide. The bed rail middle portion was divided into three sections, the outer sections had horizontal bars measuring about 4 inches	02310		

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02310	Continued From page 31 apart, and the middle section had vertical bars measuring 4 inches apart. R1's left side bed rail (farthest from the wall) was able to be easily moved from side to side (from the mattress away from the frame). The bed rail was not stable. R1's Progress Note dated March 3, 2026, indicated upon R1's arrival to the facility, R1 required significant assistance with activities of daily living (ADLs), transfers, toileting, and room set up. R1's Progress Note dated March 4, 2026, indicated R1 required "full assistance" with showering, grooming, and personal care. R1's admission assessment dated March 6, 2025 [sic], indicated on page 3 under the heading Mobility-Bed R1 was "Independent with bed mobility", however, the assessment indicated R1 had a hospital bed and needed help with turning and repositioning. The assessment also indicated, "Half ide [sic] rails for positioning and support" and R1 had expressed a desire to have bed rails. The assessment also indicated the following: - R1 did not have a cognitive deficit or fluctuations in levels of consciousness, R1 did not have visual deficits, R1 did not have a history of falls from bed, side rails were used to aide in turning/repositioning and to prevent falls, and R1 or their guardian was aware of the risks and benefits of the bed rails. The assessment further indicated R1 had a left half side rail, the bed rail was appropriate based on R1's needs and assessment, all spacing between bed and mattress was appropriate, all spacing within the bed rail was appropriate and met FDA guidelines, the bed rail was secure, ridged, and close to the mattress.	02310		

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02310	Continued From page 32 R1's assessment dated March 6, 2025 [sic], indicated R1's fall risk factors were as follows: anti-depressant mediations or medications that may impair thought process, cause vertigo, lower blood pressure, laxatives or diuretics. R1's 14-day assessment dated March 15, 2026, indicated on page 3 under the heading Mobility-Bed R1 was "Independent with bed mobility", however, the assessment indicated R1 had a hospital bed and used "Half ide [sic] rails for positioning and support" and R1 had expressed a desire to have bed rails. The assessment also indicated the following: - R1 did not have a cognitive deficit or fluctuations in levels of consciousness, R1 did not have visual deficits, R1 did not have a history of falls from bed, side rails were used to aide in turning/repositioning and to prevent falls, and R1 or their guardian was aware of the risks and benefits of the bed rails. The assessment further indicated R1 had a left half side rail, the bed rail was appropriate based on R1's needs and assessment, all spacing between bed and mattress was appropriate, all spacing within the bed rail was appropriate and met FDA guidelines, the bed rail was secure, ridged, and close to the mattress. R1's assessment dated March 15, 2026, indicated R1's fall risk factors were as follows: ambulation/mobility status, pain (gout), urinary and bowel incontinence, and anti-depressant mediations or medications that may impair thought process, cause vertigo, lower blood pressure, laxatives or diuretics. The summary also indicated that fall precautions were implemented.	02310		

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02310	Continued From page 33 R1's 90-day assessment dated June 3, 2026, indicated there was no change to R1's fall risk. Under the section Equipment, there was a check mark next to "NC" (no change), however, only listed "Neb Tx (treatment), w/c (wheelchair)". The 90-day assessment did not address R1's bilateral hospital bed rails. R1's Side-Rail use Assessment Form dated June 6, 2026, indicated R1 was not currently using the side rail for positioning or support. The form also indicated bed rail was not in use. On July 7, 2026, during the survey, clinical nurse supervisor (CNS)-A completed a Side-Rail Use Assessment Form dated July 7, 2026, for R1 and provided it to the surveyor. There was a check mark next to the statement, "Side rails do not appear to be indicated at this time." The assessment had a statement to indicate if bed rails were securely attached. The areas to indicate yes or no were both left blank and were followed by the statement, "Not in use". On July 7, 2026, at 8:54 a.m., the surveyor heard CNS-A ask R1 if they needed the bed rail or if they could remove them. R1 responded they would like them removed, however, they wished to have the right-side bed rail in place. CNS-A went ahead and removed the left side bed rail. On July 7, 2026, at 9:43 a.m., the surveyor inquired why CNS-A removed the bed rail before completing an assessment. CNS-A stated R1 needed the bed rails before moving into the licensee, however, now that they had 24 hours care they did not need the bed rails. Although R1 was admitted to the licensee with a hospital bed and bilateral bed rails in place,	02310		

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02310	Continued From page 34 during R1's admission and 14-day assessments, the licensee indicated only a left side bed rail was in place and failed to ensure the bed rails were appropriately assessed to include the following required content: documentation the bed rail was securely attached to the bed frame per manufacturer recommendations, bed rail measurements, whether the bed rail had the effect of being an improper restraint, and any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. Further, the licensee failed to conduct on-going assessment of the bed rail with their 90-day assessment. On July 7. 2026, at 12:25 p.m., CNS-A stated they were not familiar with the resources available related to bed rails. They stated they removed the left side bed rail today and intended to remove the right side later, too. They also stated R1 calls for everything and does nothing without staff assist. CNS-A further stated they did a visual assessment on R1's ability to get in/out of bed with staff before removing the left side bed rail. CNS-A stated that they had no awareness of the need to document measurements and although the FDA recommended measurement limitations for hospital bed rails was on the licensee's side rail assessment form, CNS-A stated they did not know what the recommendations were. CNS-A also stated she was unaware of the need for on-going bed rail assessment with each 90-day assessment. The Minnesota Department of Health's Assisted Living FAQs: Resident Record Requirements for Hospital-style bed rails indicated best practice for documentation about a resident's bed rails includes, but is not limited to: - purpose and intention of the bed rail;	02310		

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02310	Continued From page 35 - measurements; - the resident's bed rail use/need assessment; - risk vs. benefits discussion (individualized to each resident's risks); - the resident's preferences; - physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; - any necessary information related to interventions to mitigate safety risk or negotiated risk agreements; - consideration of whether the bed rail has the effect of being an improper restraint. Minnesota Rules Chapter 4659.0150 directs assessment of mobility, including ambulation, transfers, and assistive devices to be completed as part of the uniform assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310		

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

Food & Beverage Inspection Report

Establishment Info

Sunrise Assisting Living LLC
7708 45TH 1/2 AVE N
New Hope, MN 55428
Hennepin County
Parcel:

Phone:

License Info

License: HFID 41846

Risk:
License:
Expires on:
CFPM: Nadhra Abdille Mohamed
CFPM #: 66143; Exp: 4/3/2029

Inspection Info

Report Number: F1063261166
Inspection Type: Full - Single
Date: 7/6/2026 Time: 2:00 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 2
Total Priority 3 Orders: 1
Delivery:

New Order: 4-200 Equipment Design and Construction
4-204.112A *Priority Level: Priority 3 CFP#: 36*
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.
COMMENT: NO AMBIENT THERMOMETER LOCATED IN THE REFRIGERATOR. OPERATOR ADDED THERMOMETER DURING INSPECTION.
Comply By: Complied On Site Originally Issued On: 7/6/2026

New Order: 4-300 Equipment Numbers and Capacities
4-302.12A *Priority Level: Priority 2 CFP#: 36*
MN Rule 4626.0705A Provide a readily accessible food temperature measuring device to ensure attainment and maintenance of food temperatures.
COMMENT: NO FOOD THERMOMETER AT THE ESTABLISHMENT. DISCUSSED THE NEED TO MONITOR COOKING AND COLD HOLDING TEMPERATURES WITH OPERATOR. COMPLY WITH RULE ABOVE.
Comply By: 7/13/2026 Originally Issued On: 7/6/2026

New Order: 4-300 Equipment Numbers and Capacities
4-302.13B *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.
COMMENT: NO DISH MACHINE TEST WAS AVAILABLE DURING THE INSPECTION. PROVIDE TEST STRIPS OR THERMOMETER.
Comply By: 7/13/2026 Originally Issued On: 7/6/2026

Food & Beverage General Comment

Inspection was completed with MDH Benard Nyangena as the lead Health Regulation Division Nurse Evaluator completing the site survey.

The establishment has one resident. Discussed highly susceptible populations, glove use, same day food service, food storage & temperature control, ware washing, test kits, vomit cleanup procedures, and employee illness policy.

TEMPERATURES (DEGREES F):
KITCHEN FRIDGE: MILK 39
BEDROOM FRIDGE: WATER 41
DISH MACHINE UTENSIL SURFACE: >170

The facility has a residential kitchen. Food must be prepared for same day service only. The kitchen has vinyl panel flooring, smooth painted walls, popcorn ceiling, smooth countertops, and wooden cabinetry. All found to be in good condition.

Equipment includes a two-basin sink with one compartment designated for handwashing, and ANSI residential fridge/freezer & dish machine. There is a small fridge in the resident's bedroom.

Contact Health Regulation Division for plan review approval when facility/kitchen undergoes remodeling, major equipment additions, or changes of equipment due to a menu change.

If any customer complains of illness, establishment is required to notify the Minnesota Department of Health and provide the foodborne illness hotline phone number to the customer: 1-877-366-3455

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

I acknowledge receipt of the Metro District Office inspection report number F1063261166 from 7/6/2026

Salahaudin Mohamud
Operator

Laura Yang,
Public Health Sanitarian 1
651-201-3581
laura.yang@state.mn.us

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL41846015-0	**Date:** July 7, 2026
Facility Name: Sunrise Assisted Living LLC	
Facility Address: 7708 45 ½ Ave N, New Hope, MN 55428	

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 1; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Smoke alarms shall be interconnected so that actuation of one alarm causes all alarms in the individual dwelling or sleeping unit to operate where more than one smoke alarm is required within an individual dwelling or sleeping unit. [Minn. Stat. 144G.45 subd.2]

   Comments: There was a smoke alarm in the first floor hallway that unlicensed personnel (ULP)-D identified as the smoke alarm that is supposed to be interconnected with the other smoke alarms in the facility. The smoke alarm would not sound when tested.

   In the same area there was a second smoke alarm that ULP-D identified as the facility's carbon monoxide alarm. The alarm was a smoke and carbon monoxide combo that was interconnected with the smoke/carbon monoxide combination alarm in the lower level common hallway, but not with any other alarms in the facility.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 1; Pattern **TIME PERIOD OF CORRECTION:** Two (2) days

1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are 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. [Minn. Stat. 144G.45 subd.2]

   Comments: The door for the pantry in the first floor located near the kitchen was missing a knob and latch assembly. ULP-D stated that they were going to have it repaired and said they had already purchased the new assembly. ULP-D located a new knob/latch assembly still in the packaging inside of the pantry.

There were several bags of yard debris that were stacked up against the rear man door of the garage. Accumulation of yard waste can harbor insects and rodents.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

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1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

   Comments: The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

   Comments: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.