Electronically Delivered

April 10, 2025

Licensee
Suite Living Senior Care of Rosemount LLC
14871 Business Parkway
Rosemount, MN 55068

RE: Project Number(s) SL40479015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license with dementia care.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on March 12, 2025, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

The Department of Health concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines 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

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the

correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's residents/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.

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40479	A. BUILDING: _____ B. WING _____	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SENIOR CARE OF ROSEMOUNT	14871 BUSINESS PARKWAY ROSEMOUNT, MN 55068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL40479015-0 On March 10, 2025, through March 12, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 29 residents; 29 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the	0 730		

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0 730	Continued From page 1 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; (13) documentation of complaints received and any resolution;	0 730		

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0 730	Continued From page 2 (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 interview and record review, the licensee failed to ensure the resident record included the required documentation of all provided services 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 on October 2, 2024, with diagnoses that included diabetes and heart failure. On March 11, 2025, at 11:59 a.m., the surveyor observed an unlicensed personnel (ULP) escort R1 via her wheelchair to the dining room for lunch. R1's service agreement dated October 2, 2024, indicated R1 received services to include grooming, dressing, compression stockings, toileting, bathing, transfer and ambulation assistance, safety checks, oxygen management,	0 730		

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0 730	Continued From page 3 diabetic management, and medication administration. R1's Service Record dated March 2025, did not include documentation for the following services: -transfer assistance -ambulation assistance -escorts On March 12, 2025, at 10:40 a.m., clinical nurse supervisor (CNS)-B stated R1's record lacked documentation of all services provided. The licensee's Contents of Resident Record policy dated July 20, 2021, indicated the resident's record would include documentation that the services have been provided as identified in the service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional	01440		

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01440	Continued From page 4 and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for one of two unlicensed personnel (ULP-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 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-E was hired on November 15, 2024, to provide direct care and services to the facility's residents. On March 11, 2025, at 6:48 a.m., the surveyor observed ULP-E administer medications to R1.	01440		

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01440	Continued From page 5 ULP-E's employee record lacked documentation of a registered nurse (RN) supervising ULP-H performing a delegated task within 30 days of beginning work with the licensee. On March 12, 2025, at 10:48 a.m., regional director of nurse (RDON)-H stated ULP-E's employee record lacked evidence of a 30-day supervision of a delegated task by the RN. The licensee's Supervision of Staff- Delegated Services policy dated July 20, 2021, indicated direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for [licensee] and first performs the delegated tasks for residents and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs	01620		

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01620	Continued From page 6 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 complete fall assessments/follow up for one of one resident (R2). 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: R2 was admitted on November 4, 2024, with diagnoses that included dementia. R2's service agreement dated November 18, 2024, indicated R2 received services to include safety checks, grooming, dressing, toileting, bathing, transfer and ambulation assist, escorts,	01620		

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01620	Continued From page 7 and medication administration. R2's Individual Abuse Prevention Plan (IAPP) dated January 28, 2025, indicated R2 was not able to summon assistance/call for help by using call light or telephone and had a history of falls. On March 11, 2025, at 10:27 a.m., the surveyor observed unlicensed personnel (ULP)-F and ULP-G transfer R2 with the EZ stand out of bed and onto the toilet. R2 had a seat alarm that was in place and alerted when R2 was transferred. R2's fall reports and record review indicated the following falls and findings: - On November 8, 2024, at 12:20 p.m., clinical nurse supervisor (CNS)-B documented the following "Resident tried to give himself a shower and slipped on the wet floor. Resident states that he didn't hit his head but when writer was palpating his head, there was a spot that he said hurt. Complaints of back pain but seemed okay when we got him up. Stated he got hurt worse playing football and hockey back in the day. He takes scheduled Tylenol. Ice pack offered but he declined. 131/80, 97.5, 91%, R [respiration] 14, HR [heart rate] 88. 1 cm (centimeter) skin tear noted to left arm. Wife notified of fall'. -On November 8, 2024, at 1:45 p.m., CNS-B documented the following: "Resident had a fall out of his chair. Staff found resident lying on the floor on his left side. Writer and 2 other staff assisted resident off the floor with the hoyer lift and put him in his chair. Resident denied any new pain but had pain present from fall earlier in the day. Wife was here to see resident shortly after. Writer showed wife the bruising. Wife wanted to see how he did over the weekend stating that	01620		

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01620	Continued From page 8 even if he did have a fracture, likely nothing would be done about it. Wife requested that his prn (as needed) Tylenol be used along with ice packs as needed". -On November 8, 2024, at 3:36 p.m., CNS-B documented the following: "Resident had another fall. He was in his recliner and got up on his own. The staff heard a noise and went to check on him and found him on the floor. Wife came here and checked on him and looked at his back. She would like to just watch him for now and doesn't think he needs any imaging at this time". -On November 9, 2024, at 8:15 p.m., CNS-B documented the following: "Staff found resident sitting on the floor when rounding. Resident told staff that he was trying to go to the store and was eager to get up due to his sore butt from prior falls. No new abrasions noted at time of fall. Resident denies hitting his head. Writer gave ok to get resident up with the hoyer lift". -On November 11, 2025, at 6:15 a.m., CNS-B documented the following: "Resident found on the floor when staff went in to give medications. He was lying face down on the floor next to his bed. He was lying on his arms so staff was not able to obtain vital signs. Resident was yelling "don't touch me" when staff was attempting to roll him over. Staff asked nursing for permission to call EMS (emergency medical services) to get resident up. EMS came to assist and brought him to the hospital due to the amount of pain that resident was in". -On November 11, 2024, at 12:34 p.m., CNS-B documented the following: "Resident has been admitted to [hospital name] with T10 and T12 [thoracic region of spinal column] fracture and	01620		

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01620	Continued From page 9 fractured ribs 11 and 12 on the left side". -On November 18, 2024, R2's progress note indicated "Resident returned from the hospital today. He is an assist of 2 with hoyer lift. He is being admitted to [provider name] hospice today. They will address medications and new orders. [Resident name] returned with a foley but hospice will likely discontinue. Resident is pleasant, cooperative and vitally stable". -On December 17, 2024, at 10:58 a.m., CNS-B documented the following: "Staff heard resident calling for help, upon entering room resident was found face down on the floor. No injuries noted. 148/92, 96.9, 76, 93%. Resident was helped off the floor with the hoyer and placed in bed". -On December 28, 2024, R2's progress note indicated "Alarm sensor pad: move between chair and bed so that resident is sitting on it at all times". -On January 24, 2025, at 11:52 a.m., CNS-B documented the following: "Resident had a fall out of bed. Staff went into resident's room and found him sitting on the floor. Resident stated that he got up to go to the bathroom. No injuries noted. Hospice notified of the fall and gave ok to get him up. Writer notified wife of the fall". -On January 25, 2025, at 11:42 a.m., CNS-B documented the following: "Resident's alarm was going off. When staff entered resident's room, they found him on the floor next to his bed. Resident stated that he was looking for [wife's name]. No injuries noted. Hospice notified of fall". -On January 27, 2025, at 11:51 a.m., CNS-B documented the following: "Staff went to check	01620		

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01620	Continued From page 10 on resident and found him next to his bed. Resident stated that he was getting up to go to the bathroom and fell. No injuries noted. Resident was covered in BM. Resident was got up with 3 staff and hoyer. Brought to the shower to clean up. Bed and linens cleaned, housekeeping shampooed carpet. Wife and hospice notified of fall". -On February 18, 2025, at 10:49 a.m., CNS-B documented the following: "Call received last evening that resident had a fall. Staff reported that they heard movement in his room and went in to find him hanging onto the rail and lowering himself to the floor. No injuries noted. Hospice and wife notified". -On February 23, 2025, at 7:01 a.m., the registered nurse (RN) documented the following: "staff reported that resident was noted on the floor in his room he had had an incontinent episode of BM at the time. Staff cleaned him up and got his VS (vital signs) T [temperature] 97.6 P [pulse] 100 R [respirations] 20 B/P [blood pressure] 147/80 and O2 sats [oxygen saturation] 91% on RA [room air]. Hospice notified by facility staff and campus nurse to update MD and family on Monday. They are to call on call nurse if any changes or concern". -On February 27, 2025, at 9:02 a.m., CNS-B documented the following: "Caregiver was attaching resident to EZ-Stand while he was in his wheelchair, when pulling sling to attach he slowly slid out of wheelchair, and he was lower to the ground slowly. No apparent injury noted will continue to monitor". -On March 7, 2025, at 12:42 p.m., CNS-B documented the following: "Resident had a fall	01620		

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01620	Continued From page 11 yesterday evening at 1700. Staff were trying to transfer resident with the EZ stand from the bathroom to his chair he had a fall. Staff called hospice who gave permission to get up with the hoyer. No injuries noted. Changing care plan to assist of 2 with EZ stand". -On March 7, 2025, at 8:20 p.m., CNS-B documented the following: "Resident was in his bed and tried to get up by himself. He was sitting on the floor when staff entered his room. No apparent injuries noted. Hospice notified by staff". The licensee's RN failed to identify root cause analysis of R2's falls and implement interventions to minimize future falls. On March 12, 2025, at 9:42 a.m., CNS-B stated after each fall, she would assess the resident and implement interventions to prevent future falls. However, CNS-B stated R2's record lacked documentation of root cause analysis, and the interventions implemented to prevent future falls. The licensee's Resident Change in Condition or Need policy dated May 11, 2022, indicated the following: 1. If, as a result of the change in condition assessment, [licensee name] determines there should be a recommended change to services identified in the service plan, the facility will communicate with the resident or resident's representative to determine if the recommended change will be added to the service plan, or if the resident or resident's representative elects to decline such a service plan change. Changes, or refusal of changes, will be documented. 2. If the recommended change in service is not a service provided by [licensee name], as documented in the Uniform Disclosure of	01620		

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	40479	A. BUILDING: _____ B. WING _____	03/12/2025

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SUITE LIVING SENIOR CARE OF ROSEMOUNT	14871 BUSINESS PARKWAY ROSEMOUNT, MN 55068

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01620	Continued From page 12 Assisted Living Services and Amenities (UDALSA), the resident or resident's representative will be given the option to contract for such service to be provided by an outside provider and delivered to the resident in the assisted living community. 3. Change of condition assessments will also be initiated after every resident readmission to [licensee name] from the hospital, emergency department or other medical/treatment stay. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility 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;	01730		

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01730	Continued From page 13 (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 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 develop an individualized medication management plan with the required content for two of two residents (R1 and R2). 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:	01730		

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01730	Continued From page 14 R1 R1 was admitted on October 2, 2024, with diagnoses that included diabetes and heart failure. On March 11, 2025, at 6:48 a.m., the surveyor observed unlicensed personnel (ULP)-E administer medications to R1. R1's service agreement dated October 2, 2024, indicated R1 received services to include medication administration. R1's signed prescriber orders dated January 31, 2025, included the following: -atorvastatin calcium 20 milligrams (mg); take one tablet by mouth once daily (cholesterol) -buprenorphine transdermal patch 10 micrograms (mcg)/hour; Apply one patch one time a day every Monday (joint pain) -ferrous sulfate 325 mg; take one tablet by mouth one time a day (supplement) -magnesium oxide 400 mg; take one tablet by mouth one time a day (supplement) -melatonin 3 mg; take two tablets by mouth at bedtime (sleep) -metformin 500 mg; take one tablet by mouth one time a day (diabetes) -pantoprazole sodium 40 mg; take one tablet by mouth one time a day (reflux) -trazodone 50 mg; take one half tablet by mouth at bedtime (sleep) -Vitamin D3 25 mcg; take one tablet by mouth one time a day (supplement) -Eliquis 5 mg; take one tablet by mouth two times a day (blood thinner) -Flucinonide External Solution 0.05%; Apply to scalp topically two times a day (eczema) -Fluticasone-Salmeterol inhalation 100-50 mcg;	01730		

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01730	Continued From page 15 one puff inhale orally two times a day (asthma) -torsemide 20 mg; take two tablets by mouth two times a day (heart failure) -acetaminophen 500 mg; take two tablets by mouth three times a day (pain) -gabapentin 400 mg; take one capsule by mouth three times a day (pain) -albuterol sulfate inhalation; two puffs inhale orally every six hours as needed (shortness of breath) -albuterol sulfate inhalation nebulization solution 0.083%; one vial inhale orally every six hours as needed (shortness of breath) -antacid calcium 500 mg tablets; give two tablets by mouth every one hour as needed (heartburn) -aspirin 325 mg; give one tablet by mouth as needed for chest pain, instructed by 911 emergency medical services operator -bisacodyl laxative suppository 10 mg; insert one suppository rectally as needed (constipation) -guaifenesin 100 mg/5 milliliter(ml); give 10 ml by mouth every four hours as needed (cough) -hydrocortisone cream 1%; apply to affected skin area topically as needed for insect bites, rashes, minor skin irritations, up to four times a day -loperamide 2 mg; take one tablet by mouth once daily as needed (loose stools) -menthol cough drops; give one lozenge by mouth every hour as needed (cough) -milk of magnesia; give 30 ml by mouth every 24 hours as needed (constipation) -muscle rub external cream 10-15%; apply to right hip topically every six hours as needed (pain) -senna-tabs; give one tablet by mouth every 12 hours as needed (constipation) -simethicone 80 mg; take one tablet by mouth every six hours as needed for gas -tizanidine 2 mg; take one tablet by mouth every eight hours as needed (muscle spasms)	01730		

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01730	Continued From page 16 R1's Individualized Medication Management Plan dated October 2, 2024, lacked identification of all medication management tasks that may be delegated to unlicensed personnel, rectal medications R2 R2 was admitted on November 4, 2024, with diagnoses that included dementia. On March 11, 2025, at 8:31 a.m., the surveyor observed ULP-F administer medications to R2. R2's service agreement dated November 18, 2024, indicated R2 received services to include medication administration. R2's signed prescriber orders included the following: -escitalopram oxalate 20 mg; take one tablet by mouth one time a day (depression), order dated November 18, 2024 -melatonin 5 mg; give one tablet by mouth at bedtime (sleep), order dated November 18, 2024 -senna-docusate 8.6-50 mg; take one tablet by mouth one time a day (constipation), order dated November 22, 2024 -buspirone 10 mg; take one tablet by mouth two times a day (anxiety), order dated January 24, 2025 -lorazepam 0.5 mg; take one tablet by mouth two times a day (restlessness), order dated January 24, 2025 -acetaminophen 500 mg; take two tablets by mouth three times a day (pain), order dated November 20, 2024 -acetaminophen 325 mg; give two tablets by mouth every four hours as needed (fever, headache or pain), order dated November 18, 2024	01730		

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01730	Continued From page 17 -antacid calcium 500 mg tablets; take two tablets by mouth every one hour as needed (heartburn), order dated November 18, 2024 -aspirin 325 mg; give one tablet by mouth as needed for chest pain, instructed by 911 emergency medical services operator, order dated November 18, 2024 -bisacodyl laxative suppository 10 mg; insert one suppository rectally as needed (constipation), order dated November 18, 2024 -Claritin 10 mg; give one tablet by mouth every 24 hours as needed (nasal congestion), order dated November 18, 2024 -guaifenesin 100 mg/5 milliliter(ml); give 10 ml by mouth every four hours as needed (cough), order dated November 18, 2024 -hydrocortisone cream 1%; apply to affected skin area topically as needed for insect bites, rashes, minor skin irritations, up to four times a day, order dated November 18, 2024 -haloperidol 0.5 mg; give one tablet by mouth every six hours as needed (agitation or nausea), order dated November 18, 2024 -hydromorphone 2 mg; give one-half tablet by mouth every two hours as needed (pain or shortness of breath), order dated November 18, 2024 -lorazepam 0.5 mg; take one tablet by mouth every four hours as needed (restlessness or anxiety), order dated November 18, 2024 -loperamide 2 mg; take one tablet by mouth once daily as needed (loose stools), order dated January 17, 2025 -menthol cough drops; give one lozenge by mouth every hour as needed (cough), order dated November 18, 2024 -milk of magnesia; give 30 ml by mouth every 24 hours as needed (constipation), order dated November 18, 2024 -senna 8.6 mg; give one tablet by mouth every 12	01730		

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01730	Continued From page 18 hours as needed (constipation), order dated November 22, 2024 R2's Individualized Medication Management Plan dated November 18, 2024, lacked identification of all medication management tasks that may be delegated to unlicensed personnel, rectal medications. On March 12, 2025, at 10:43 a.m., clinical nurse supervisor (CNS)-B stated R1 and R2's Individualized Medication Management plan did not include identification of medication management tasks (rectal medications) that may be delegated to the unlicensed personnel, The licensee's Medication Management Individualized Plan policy dated July 2021, indicated the Individualized Medication management record would include identification of medication management tasks that may be delegated to unlicensed personnel. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for	01750		

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01750	Continued From page 19 each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse documented resident-specific instructions for one of two residents (R1) whose medication administration was delegated to unlicensed personnel (ULP). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted on October 2, 2024, with diagnoses that included diabetes and heart failure. R1's service agreement dated October 2, 2024, indicated R1 received services to include medication administration. R1's signed prescriber orders dated January 31, 2025, included the following: -flucinonide External Solution 0.05%; Apply to scalp topically two times a day (eczema) -fluticasone-salmeterol inhalation 100-50 mcg; one puff inhale orally two times a day (asthma)	01750		

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01750	Continued From page 20 On March 11, 2025, at 6:48 a.m., the surveyor observed ULP-E prepare R1's medications which included an fluticasone-salmeterol inhaler. ULP-E gave the inhaler to R1 who self-administered one puff as ordered. ULP-E did not offer or instruct R1 to rinse her mouth after administering the inhaler. ULP-E then applied a quarter size amount of flucinonide external solution cream to the top or R1's head. ULP-E massaged the cream all over R1's scalp. ULP-E applied an additional quarter sized amount of the flucinonide cream to R1's scalp. The surveyor inquired how the ULP knew how cream to apply to R1's scalp and ULP-E stated she used enough to cover R1's entire scalp and would add more if R1 felt not enough of the cream was applied. On March 12, 2025, at 10:19 a.m., regional director of nursing (RDON)-H stated the ULP should have reminded R1 to rinse her mouth after using the inhaler. RDON-H stated the flucinonide cream did not have a recommended dose included in the order and that staff would apply a thin layer of the cream to cover R1's scalp. ALBUTEROL R1's signed prescriber orders dated January 31, 2025, included the following: -albuterol sulfate inhalation; two puffs inhale orally every six hours as needed (shortness of breath) -albuterol sulfate inhalation nebulization solution 0.083%; one vial inhale orally every six hours as needed (shortness of breath) The licensee failed to have resident-specific instructions regarding when to use the albuterol sulfate inhaler versus the albuterol sulfate nebulizer when R1 was short of breath. The licensee's Medication and Treatment -	01750		

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01750	Continued From page 21 Administration and Delegation policy dated July 2021, indicated prior to ULP providing delegated medication administration and/or treatments/therapy, the following must occur: 1. A RN must conduct a face-to face resident assessment to determine what medication management or treatment/therapy services will be provided and how those services will be provided. 2. [Licensee] will prepare and include in the service plan a written statement of the medication management or treatment/therapy services that will be provided to the resident. 3. The medications have current prescriber's orders on file. 4. A RN must specific, in writing, specific instructions for each resident and document those instructions in the resident's record. The Fluticasone Salmeterol inhalation direction for use dated January 2020, indicated to rinse your mouth with water after breathing in the medicine. Spit out the water. Do not swallow it. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current	01940		

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01940	Continued From page 22 individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the	01940		

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01940	Continued From page 23 situation has occurred only occasionally). The findings include: R1 was admitted on October 2, 2024, with diagnoses that included diabetes and heart failure. On March 11, 2025, at 6:56 a.m., the surveyor observed unlicensed personnel (ULP)-E check R1's blood sugar. R1's service agreement dated October 2, 2024, indicated R1 received services to include compression stockings, vital sign monitoring (daily weights) oxygen management, and diabetic management. R1's signed prescriber orders included the following: -Check oxygen saturations every shift, apply oxygen if saturations are less than 90%, order dated February 12, 2025. -Oxygen 2 liters per nasal cannula as needed for oxygen saturations less than 90%, order dated February 12, 2025. -Blood glucose checks two times a day, order dated February 12, 2025. -Daily weights, order dated September 30, 2024. -Compression Stockings, knee high, bilateral. Apply daily in AM (morning) and remove daily at HS (bedtime), order dated November 27, 2024. R1's Individualized Treatment and Therapy Management Plan dated October 2, 2024, included: -Blood Glucose Monitoring -Compression Garments -Oxygen Management -Vital Signs	01940		

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01940	Continued From page 24 -Weight Monitoring R1's Individualized Treatment and Therapy Management plan lacked documentation of specific resident instructions relating to the treatments or therapy administration, for blood glucose monitoring and compression stockings. On March 12, 2025, at 10:29 a.m., clinical nurse supervisor (CNS)-B stated R1's individualized treatment management plan lacked the required content as noted above. The licensee's Medication and Treatment-Administration and Delegation policy dated July 2021, indicated when administration of medications or treatment/therapy is delegated or assigned to unlicensed personnel, [licensee] would ensure the registered nurse has: 2. specified, in writing, specific instructions for each resident and documented those instructions in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40479	A. BUILDING: _____ B. WING _____	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SENIOR CARE OF ROSEMOUNT	14871 BUSINESS PARKWAY ROSEMOUNT, MN 55068

(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
01960	Continued From page 25 document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment or therapies were administered as prescribed, or to document the reason they were not provided, for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted on October 2, 2024, with diagnoses that included diabetes and heart failure. On March 11, 2025, at 6:56 a.m., the surveyor observed unlicensed personnel (ULP)-E check R1's blood sugar. R1's service agreement dated October 2, 2024, indicated R1 received services to include compression stockings, vital sign monitoring (daily weights) oxygen management, and diabetic management. R1's signed prescriber orders included the following:	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40479	A. BUILDING: _____ B. WING _____	03/12/2025

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01960	Continued From page 26 -Check oxygen saturations every shift, apply oxygen if saturations are less than 90%, order dated February 12, 2025. -Oxygen 2 liters per nasal cannula as needed for oxygen saturations less than 90%, order dated February 12, 2025. -Blood glucose checks two times a day, order dated February 12, 2025. -Daily weights, order dated September 30, 2024. -Compression Stockings, knee high, bilateral. Apply daily in AM (morning) and remove daily at HS (bedtime), order dated November 27, 2024. On March 11, 2025, at 7:04 a.m., R1 stated she used oxygen during the night and the ULP assisted her with turning the oxygen on and verifying that it was set at 2 liters. R1 stated the ULP also assisted her with putting on her compression stockings when she was unable to herself. On March 12, 2025, at 10:33 a.m., clinical nurse supervisor (CNS)-B stated R1's record lacked documentation of the services listed above. The license's Medication and Treatment Record-Documentation and Refusal policy dated July 20, 2021, indicated documentation of medication/treatment/therapy reminders, medication treatment/therapy assistance or medication/treatment/therapy administration will be completed by the person who performed the task immediately after the medication assistance/administration completed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		

Minnesota Department of Health
Food, Pools and Lodging Services Section
625 N Robert St
St Paul, MN 55164
651-201-4500

Type: Full
Date: *03/11/25*
Time: 14:57:37
Report: 7963251012

Food and Beverage Establishment Inspection Report

Location:
Suite Living Senior Care of Ro
14871 Business Parkway
Rosemount, MN55068
Dakota County, 19

Establishment Info:
ID #: 0044017
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/25

Operator:

Phone #: 6517702273
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 161 Degrees Fahrenheit
Location: DISHWASHER RINSE
Violation Issued: No

Acid: = 700 PPM at Degrees Fahrenheit
Location: SANI DISPENSER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 40 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: CUT LETTUCE
Temperature: 40 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

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

MET WITH MDH NURSE SURVEYOR KASSIE MARKING AND ESTABLISHMENT REPRESENTATIVE MICAH PRZYBYLSKI. DISCUSSED THE FOLLOWING-

-EMPLOYEE ILLNESS POLICY AND LOG
-SUSCEPTIBLE POPULATION RESTRICTIONS
-VOMIT/FECAL CLEAN UP
-USE OF PASTEURIZED EGGS
-HIGH TEMP DISHWASHERS

Type: Full
Date: *03/11/25*
Time: 14:57:37
Report: 7963251012
Suite Living Senior Care of Ro

Food and Beverage Establishment Inspection Report

THIS IS A COMMERCIAL KITCHEN.

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 7963251012 of 03/11/25.

Certified Food Protection Manager: Micah Przybylski

Certification Number: FM 120868 Expires: 01/08/27

Inspection report reviewed with person in charge and emailed.

Signed: _____

Micah Przybylski
PIC

Signed: Peggy Spadafore

Peggy Spadafore
Sanitarian Supervisor
metro
651-201-4500
peggy.spadafore@state.mn.us

Report #: 7963251012

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools and Lodging Services Section
625 N Robert St
St Paul, MN 55164

No. of RF/PHI Categories Out	0	Date	03/11/25
No. of Repeat RF/PHI Categories Out	0	Time In	14:57:37
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Suite Living Senior Care of Ro	14871 Business Parkway	Rosemount, MN	55068	6517702273

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0044017		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item. Mark "X" in appropriate box for COS and/or R.

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status		COS	R
Supervision			
1	IN OUT		
2	IN OUT N/A		
Employee Health			
3	IN OUT		
4	IN OUT		
5	IN OUT		
Good Hygenic Practices			
6	IN OUT N/O		
7	IN OUT N/O		
Preventing Contamination by Hands			
8	IN OUT N/O		
9	IN OUT N/A N/O		
10	IN OUT		
Approved Source			
11	IN OUT		
12	IN OUT N/A N/O		
13	IN OUT		
14	IN OUT N/A N/O		
Protection from Contamination			
15	IN OUT N/A N/O		
16	IN OUT N/A		
17	IN OUT		

Compliance Status		COS	R
Time/Temperature Control for Safety			
18	IN OUT N/A N/O		
19	IN OUT N/A N/O		
20	IN OUT N/A N/O		
21	IN OUT N/A N/O		
22	IN OUT N/A		
23	IN OUT N/A N/O		
24	IN OUT N/A N/O		
Consumer Advisory			
25	IN OUT N/A		
Highly Susceptible Populations			
26	IN OUT N/A		
Food and Color Additives and Toxic Substances			
27	IN OUT N/A		
28	IN OUT		
Conformance with Approved Procedures			
29	IN OUT N/A		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance. Mark "X" in appropriate box for COS and/or R. **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30	IN OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT N/A	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 03/11/25

Inspector (Signature) Peggy Spudy