



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 8, 2025

Licensee
Suite Living of Roseville
197 County Road B2 West
Roseville, MN 55113

RE: Project Number(s) SL33954016

Dear Licensee:

On June 26, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on May 1, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the May 1, 2025 survey.

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.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on May 1, 2025, found not corrected at the time of the June 26, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0510-Infection Control Program-144g.41 Subd. 3

The details of the violations noted at the time of this follow-up survey completed on June 26, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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 licensee must document actions taken to comply with the correction orders outlined on the state form; however, plans of correction are not required to be submitted for approval.

IMPOSITION OF FINES:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in §144G.20 for widespread violations;

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

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

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>

We urge you to review these orders carefully. If you have questions, please contact Jess Schoenecker at 651-201-3789.

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

Sincerely,



Jess Schoenecker, Supervisor
State Evaluation Team

Email: Jess.Schoenecker@state.mn.us

Telephone: 651-201-3789 Fax: 1-866-890-9290

KKM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33954	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/26/2025
NAME OF PROVIDER OR SUPPLIER SUITE LIVING OF ROSEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 197 COUNTY ROAD B2 WEST ROSEVILLE, MN 55113		
(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL33954016-1 On June 24, 2025, to June 26, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on May 1, 2025. At the time of the survey, there were 20 residents; all 20 residents were receiving services under the Assisted Living with Dementia Care license. As a result of the follow-up survey, the following orders were reissued.	{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}			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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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, existing floor, wall, and ceiling finishes are	{0 480}			

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{0 480}	Continued From page 2 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:	{0 480}	Not reviewed during this survey.		
{0 510} SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complied with accepted health care, medical and	{0 510}			

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{0 510}	Continued From page 3 nursing standards for infection control related to catheter care for one of two residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On June 24, 2025, at 10:10 a.m., clinical nurse supervisor (CNS)-A stated staff had been retrained on catheter care and infection control practices. On June 24, 2025, at 10:20 a.m., the surveyor and clinical nurse supervisor (CNS)-A entered R5's room together and observed R5's urinary drainage bag hanging from a 2-wheel walker with the drain spout lying directly on the carpet. CNS-A said the drain spout should not have been on the floor and proceeded to apply gloves, grabbed a urinal and drained the urine from the catheter bag into the urinal then wiped the drain spout with an alcohol wipe and placed the drain spout into the sleeve (covered area to help drain spout from touching contaminates). At 10:25 a.m., R5 stated she was on antibiotics for a urinary tract infection which CNS-A confirmed that was true. The surveyor then walked into R5's bathroom and observed another urinary drainage bag wrapped over the grab bar near the toilet and observed the opening of the tube (end that connects to the indwelling urinary catheter) lying on the bathroom floor behind a garbage can with a used vinyl	{0 510}			

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{0 510}	Continued From page 4 glove resting on top of it. The surveyor observed an empty basin on the floor nearby. CNS-A stated the drainage bag in the bathroom was used for overnight and was placed on the grab bar to dry but the tubing should not have been on the floor but in the basin instead. R5's [Licensee] Service Agreement-V5 dated May 1, 2025, indicated R5 received catheter care assistance. R5's prescriber orders dated June 23, 2025, noted R5 stop using cephalexin and start ciprofloxacin 500 milligrams (mg), by mouth twice daily for seven days. The licensee's 6.39 Cleaning drainage or leg bag for reuse policy dated August 1, 2021, indicated the licensee would provide safe and clean care of drainage bags to decrease risk of infection. The policy indicated after cleaning the drainage bag, hang the bag to air dry completely, making sure no areas of the catheter are touching the ground. No further information was provided.	{0 510}			
{0 650} SS=F	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 information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency	{0 650}			

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{0 650}	Continued From page 5 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:	{0 650}	Not reviewed during this survey.		
{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	{0 680}			

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{0 680}	Continued From page 6 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:	{0 680}	Not reviewed during this survey.		
{0 730} SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the	{0 730}			

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{0 730}	Continued From page 7 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; (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:	{0 730}	Not reviewed during this survey.		
{0 790} SS=D	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and	{0 790}			

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{0 790}	Continued From page 8	{0 790}			
{0 810} SS=F	This MN Requirement is not met as evidenced by: 144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	{0 810}	Not reviewed during this survey.		

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{0 810}	Continued From page 9	{0 810}			
	This MN Requirement is not met as evidenced by:		Not reviewed during this survey.		
{0 900} SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the	{0 900}			

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{0 900}	Continued From page 10 existing contract must be executed and signed. This MN Requirement is not met as evidenced by:	{0 900}	Not reviewed during this survey.		
{01640} SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by:	{01640}			
{01890} SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for	{01890}	Not reviewed during this survey.		

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{01890}	Continued From page 11 immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by:	{01890}	Not reviewed during this survey.		
{01960} SS=E	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 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:	{01960}			
{02310} SS=E	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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(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	
{02310}	Continued From page 12 This MN Requirement is not met as evidenced by:	{02310}	Not reviewed during this survey.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 12, 2025

Licensee

Suite Living of Roseville
197 County Road B2 West
Roseville, MN 55113

RE: Project Number(s) SL33954016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 1, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

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

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

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

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at

the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: <https://forms.office.com/g/Bm5uQEPhVa>. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in dark ink, appearing to read 'Jess', with a stylized flourish extending to the right.

Jess Schoenecker, Supervisor

State Evaluation Team

Email: Jess.Schoenecker@state.mn.us

Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33954	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/01/2025
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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: SL33954016-0 On April 28, 2025, through May 1, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 19 residents; all 19 received 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.		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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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, existing floor, wall, and ceiling finishes are	0 480			

Minnesota Department of Health

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0 480	Continued From page 2 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 April 28, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480			

Minnesota Department of Health

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480			
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical, and nursing standards for infection control for two of three employees (unlicensed personnel (ULP)-E, ULP-B). In addition, the licensee failed to keep catheter tubing contained and off the floor for two of two residents (R2, R5). 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).	0 510			

Minnesota Department of Health

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0 510	Continued From page 4 The findings include: HAND HYGIENE ULP-E On April 29, 2025, at 9:11 a.m., the surveyor observed ULP-I (a ULP in training) observing ULP-E and ULP-H assist R3 transfer from a Broda chair (oversized wheelchair with cushions) to the bed using a full body mechanical lift. Both ULP-E and ULP-H wore gloves and removed R3's brief, and ULP-E provided perineal care in the front then rolled R3 to the left side to wipe the back end. ULP-E and ULP-H applied a new brief and without removing the gloves after wiping, ULP-E touched R3's left upper bed rail, then the glove box by moving it, then removed the gloves and disposed of them. ULP-E came back to R3's bed, and put the other bed rail up, touched the remote of the bed to adjust it, then left. Once out of the room, ULP-E washed her hands at the sink. The surveyor did not observe any hand washing or hand sanitizing directly after glove removal on any staff that performed cares. On April 29, 2025, at 1:25 p.m., ULP-E stated clinical nurse supervisor (CNS)-A trained her on infection control. On April 29, 2025, at 3:00 p.m., CNS-A stated staff had been trained to remove gloves after they are soiled and perform hand hygiene. CNS-A expected gloves be removed after performing perineal care. ULP-B On April 29, 2025, at 11:50 a.m., ULP-B gave medications to R4 then grabbed R4's blood glucose monitor kit and wiped R4's finger with an alcohol wipe, poked R4's finger with a lancet	0 510			

Minnesota Department of Health

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0 510	Continued From page 5 (one-time use needle) and wiped away the first drop of blood then placed the monitor to the second drop of blood. ULP-B then removed his gloves and placed the kit back into the medication cart and documented the result on the computer. The surveyor did not observe hand hygiene performed. ULP-B then grabbed the monitor for R5's Freestyle sensor and obtained the blood glucose result by placing the monitor to the arm sensor. ULP-B then went back to the computer and documented the result. The surveyor did not observe hand hygiene completed. CATHETER On April 29, 2025, at 9:35 a.m., the surveyor observed R2 and R5 in the television/activity room area sitting in their manual wheelchairs with catheter bags hooked to the frame of the wheelchair. The tubing of both catheters were touching the floor. ULP-B stated they tried to place the catheter bag as high up as possible on the back of the wheelchair to try to avoid the tubing from touching the floor. On April 29, 2025, at 11:30 a.m., the surveyor pointed out R5's catheter tubing touching the floor of the activity area, and she stated that was an infection control issue. The licensee's 8.07 Gloves policy dated July 20, 2021, instructed staff to remove a contaminated material and place it in the proper receptacle and remove gloves followed by hand washing. The licensee's 8.09 Hand Washing policy dated July 20, 2021, instructed staff to perform hand washing after changing a brief or after cleaning up after someone who has used the toilet to prevent cross-contaminations. The policy also indicated when conducting a procedure requiring	0 510			

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0 510	Continued From page 6 the use of gloves, proper hand hygiene should be completed before donning (applying) gloves and after removing gloves. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 650 SS=F	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 information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training 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 observation, interview, and record	0 650			

Minnesota Department of Health

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0 650	Continued From page 7 review, the licensee failed to ensure the employee record contained the required content for two of two unlicensed personnel ((ULP)-B, 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was hired on October 11, 2021, to provide direct assisted living services to the licensee's residents. During observation on April 29, 2025, at 8:32 a.m., ULP-B administered medications to R2 and at 11:50 a.m., administered medications to R4 and checked her blood glucose level. ULP-E ULP was hired on February 19, 2024, to provide direct assisted living services to the licensee's residents. During observation from April 28 through May 1, 2025, throughout the survey, the surveyor was set up in an empty room just outside the television area and observed three residents in Broda chairs (oversized wheelchair with cushions) in that area for various periods of time. COMPETENCIES	0 650			

Minnesota Department of Health

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0 650	Continued From page 8 On April 29, 2025, at 9:11 a.m., the surveyor observed ULP-E, ULP-H, and ULP-I (trainee observing) assist R3 transfer from a Broda chair (oversized wheelchair with cushions) to the bed using a full body mechanical lift and provided toileting assistance. ULP-B and ULP-E's training records lacked training and skill competency on use of Broda chairs. During interview on May 1, 2025, at 11:22 a.m., the surveyor asked licensed assisted living director (LALD)-D if there were documentation of training and skill competency on use of Broda chairs, and she stated she was not sure and would get back to the surveyor. LALD-D explained that during skills training upon hire, staff were trained on Hoyer (full body lift) lift, sit to stand machine, but was not sure if there was a Broda chair as part of the training. On May 1, 2025, at 12:01 p.m., via electronic mail, LALD-D indicated she spoke with the licensee's training and education nurse who confirmed that they train on Broda chairs but did not document the demonstrated competency for all staff. PERFORMANCE REVIEW ULP-B and ULP-E's undated Annual Review lacked dates of when the performance evaluations were completed and signatures of both supervisor and employee. On April 29, 2025, at 1:25 p.m., ULP-E stated she received a performance review with LALD-D but could not remember when that was completed. On May 1, 2025, at 2:57 p.m., via electronic mail,	0 650			

Minnesota Department of Health

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0 650	Continued From page 9 housing director (HD)-C indicated all annual performance evaluations were completed on their human resource platform (Isolved) once a year. Supervisors notify employees of their upcoming review and once completed, both supervisor and employee go over the evaluation. The performance evaluation was supposed to be dated and signed per HD-C. The licensee's 5.02 Competency Training Evaluations policy dated July 20, 2021, indicated prior to the delegation of services, ULP's would be trained in proper methods to perform the tasks or procedures for each resident and demonstrate the ability to competently follow the procedures and perform the tasks. The policy also indicated a copy of all education, training, and competency testing shall be kept in each employee's personnel file. The licensee's 4.35 Employee Evaluation policy dated July 20, 2021, indicated all staff of licensee would be given an employee evaluation at least annually. The evaluation form was to be signed by the supervisor and the employee. The original signed form to be placed in the employee's personnel file and a copy of the completed and signed form would be given to the employee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements:	0 680			

Minnesota Department of Health

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0 680	Continued From page 10 (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. The licensee also failed to document annual review/revisions. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	0 680			

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0 680	Continued From page 11 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 EPP dated October 1, 2022, and approved by licensed assisted living director (LALD)-D on October 4, 2022, lacked evidence of the following required content: -develop and maintain the EPP-must be updated annually; -maintain and annual EPP updates-lacked plan to address power outage and winter storms based on hazard vulnerability assessment; -missing resident policy review last documented on October 8, 2024 (must be reviewed quarterly); and - policies and procedures including evacuation to include procedures for evacuating staff and residents. On April 30, 2025, at 3:00 p.m., LALD-D stated they had started transportation plans which was used in their prior EPP before the current EPP was implemented and needed to be added to the current EPP. LALD-D stated she had been reviewing the missing resident policy but did not document the reviews. The licensee's undated Emergency Management Policy indicated the licensee will 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 680			

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0 680	Continued From page 12 (21) days	0 680			
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been	0 730			

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0 730	Continued From page 13 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; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the resident record included documentation of daily catheter care as specified in the service agreement for two of two residents (R2, R5). In addition, the licensee failed to ensure resident records included documentation of resident's receipt and review of uniform disclosure of services (UDALSA) for four of five residents (R5, R7, R8, R9), and dementia care policies and procedures for five of five residents (R3, R5, R7, R8, R9). 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: CATHETER CARE R2 and R5's medical record lacked	0 730			

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0 730	Continued From page 14 documentation of completing foley catheter care. R2 R2 was admitted for services on September 6, 2024, and had diagnoses including type 2 diabetes, Parkinsonism (slowed movements, stiffness, and tremors), depression, anxiety disorder, chronic obstructive pulmonary disease, and asthma. R2's [Licensee] Service Agreement -V5 signed September 6, 2024, indicated R2 received assistance with safety checks, modified diet, medication administration, diabetic management including blood glucose checks, bathing, dressing, and grooming. R2's hospital discharge record dated March 31, 2025, indicated R2 was admitted due to altered mental status, and dark-colored urine which appeared to be severe urinary tract infection. R2 received antibiotic treatment. The discharge record provided instructions on when to empty the urinary bag and provided education on how to empty or flush the bag (education was not attached for surveyor to view). R5 R5 was admitted for services on June 4, 2021, and had diagnosis including bipolar disorder (extreme mood swings including manic and major depression), chronic pain, osteoarthritis, type 2 diabetes, sleep disorders, and history of urinary tract infection. R5's [Licensee] Service Agreement-V5 signed December 4, 2024, indicated R5 received assistance with catheter care by changing, emptying, and replacing the bag as scheduled.	0 730			

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0 730	Continued From page 15 During interview on April 30, 2025, at 10:30 a.m., unlicensed personnel (ULP)-B explained he cleaned the catheter bag by flushing the bag with saline every morning and wiping the opening of the catheter (where urine drained) with alcohol wipe prior to emptying the bag. During interview on April 30, 2025, at 12:35 p.m., the surveyor observed R5 sitting on her power wheelchair placing her catheter drain bag into another bag. R5 stated she received assistance with cleaning around her suprapubic (tube that drains urine from bladder through small opening of abdomen) site and emptying of the drain bag and using an alcohol wipe to clean the drain spout. She stated staff did not clean her catheter drainage bag with solution or change the bag unless it was leaking. During interview on April 30, 2025, at 1:30 p.m., clinical nurse supervisor (CNS)-A stated staff should be cleaning catheter drainage bags with water/vinegar solution on the overnight shift but could not find specific instructions within R2 and R5's service tasks. CNS-A stated the catheter task on R2 and R5's service plans instructed staff to empty the bag every four (4) hours. CNS-A then found in the history on the R5's electronic health record (PointClickCare) that the cleaning task was initiated back on August 17, 2022, then discontinued May 2024, and stated she did not know why it was stopped. CNS-A restarted the service this same day. R2's cleaning task was not found. During phone interview on May 1, 2025, at 9:26 a.m., ULP-G stated she was trained on catheter care and the procedure was to mix one part water and three parts vinegar (she was unsure of the parts for each) and pour it into the bag at the end	0 730			

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0 730	Continued From page 16 of her shift (2:00 p.m.-10:00 p.m.) and documented it on the resident's electronic health record (could not specify where she documented that task). ULP-B's Catheter Care competency dated October 17, 2022, indicated to clean the drainage bag daily with equal parts vinegar and water. Leave the solution in bag for 20 minutes, empty and rinse bag with clean water. Hang upside down to dry. The licensee's 6.39 Cleaning drainage or leg bag for reuse policy dated August 1, 2021, indicated the licensee would provide safe and clean care of drainage bags to decrease risk of infection. The procedure for clean care of drainage bag indicated to fill the bag with clean water and shake to rinse well, then drain into the toilet. This was to be done twice. Use a funnel, pour the vinegar or bleach solution into the empty bag. Shake the bag for 30-60 seconds then drain the bag. Clean the tubing and ends of bags with bleach/vinegar solution and hang to air dry completely. Document task. UDALSA/DEMENTIA POLICIES R5, R7, R8, and R9 began services under the licensee's former comprehensive licensure on June 4, 2021, December 28, 2018, April 28, 2020, and December 3, 2018, respectively, and all began receiving assisted living services as of August 1, 2021. R3 began assisted living services on November 9, 2021. R5, R7, R8, and R9's records lacked documentation of resident's receipt and review of the UDALSA and dementia care policies and	0 730			

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0 730	Continued From page 17 procedures. R3's record lacked documentation of resident/legal representative and designated representatives received dementia care policies and procedures. On May 1, 2025, at 11:39 a.m., via electronic mail, housing director (HD)-C indicated upon admission, every resident and/or their designated representative received dementia care policies and procedures by paper format and documented that under the resident's PointClickCare. HD-C was unable to provide evidence that UDALSA and dementia care policies and procedures were provided. The licensee's 1.04 Uniform Disclosure of Assisted Living Services & Amenities (UDALSA) policy dated August 1, 2021, indicated the licensee would obtain written acknowledgement from the resident or resident representative that licensee provided the UDALSA or document the reason why an acknowledgement was not obtained. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced	0 775			

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0 775	Continued From page 18 by: Based on observation and interview, the licensee failed to maintain facility in compliance with Minnesota State Fire Code under Minnesota Rules Chapter 7511. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 28, 2025, from approximately 1:07 p.m. to 2:40 p.m., the surveyor toured the facility with the licensed assisted living director (LALD)-D. During the tour, the surveyor observed the following deficient conditions: SPRINKLER SYSTEM Boxes and materials were stored in front of the sprinkler head in the front entry closet. The proper clearance to ensure sprinkler system functions properly was not maintained which could limit the effectiveness of the sprinkler in a fire emergency. LALD-D verified the storage issues and stated that obstructing items would be removed, and staff would be reminded about proper storage. Materials were stored in front of the sprinkler head in the staff storage closet near resident room 5. The proper clearance to ensure sprinkler system functions properly was not maintained	0 775			

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0 775	Continued From page 19 which could limit the effectiveness of the sprinkler in a fire emergency. LALD-D verified the storage issues and stated that obstructing items would be removed, and staff would be reminded about proper storage. FIRE DOOR The fire door between West side and East side of the facility between the offices and kitchen were propped open with a wooden doorstop which would prevent fire doors from closing in an emergency. This door should be maintained to function in its intended use and should be self-closing or automatic closing to limit the spread of smoke and fire throughout the facility. LALD-D acknowledge this door was a fire rated assembly and stated that it would not be propped with a door stop. The nurse evaluator indicated that on subsequent days of the survey that this fire door was maintained propped open by door stop during the entire duration observed during the survey. CONTROLLED EGRESS REMOTE RELEASE The facility has controlled egress doors which release with activation of the fire alarm system, however no remote release signal or switch was present. LALD-D confirmed to the surveyor that the facility did not have ability to remotely signal to break power to door lock. The facility should have a button, switch or other signaling device to release controlled egress doors when activated. On April 28, 2025, the surveyor explained to LALD-D the requirements for sprinkler heads, remote release controls, and fire doors. LALD-D stated they understood requirements and would make appropriate changes.	0 775			

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0 775	Continued From page 20	0 775			
	TIME PERIOD FOR CORRECTION: Seven (7) days.				
0 790 SS=D	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On April 28, 2025, from approximately 1:07 p.m. to 2:40 p.m., the surveyor toured the facility with the licensed assisted living director (LALD)-D.	0 790			

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0 790	Continued From page 21 During the tour, the surveyor observed the following deficient conditions: The fire extinguisher in the water heater room on the East side of the property did not have current annual service tags. The tag on this extinguisher indicated it was last serviced in October of 2020. All extinguishers should have current annual service tags to ensure proper function and maintenance. During the tour LALD-A verified the annual testing had not been on this extinguisher and indicated it was missed in annual testing. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be	0 810			

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0 810	Continued From page 22 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 develop the fire safety and evacuation plan with required content and provide required documentation. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 28, 2025, at approximately 2:15 p.m., director of maintenance (DM)-H provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training.	0 810			

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0 810	Continued From page 23 The licensee FSEP failed to include the following: The FSEP did not readily include procedures for resident movement and evacuation with identification of unique and unusual resident needs. Information about resident needs during evacuation should be readily accessible and available to all employees. The FSEP did not include fire procedures for residents. Procedures should be available for residents indicating what to do in a fire event. During the record review and interview on April 28, 2025, LALD-D verified the above listed documents were absent from the FSEP. LALD-D stated that they understood requirements and would supplement the existing FSEP with missing information and documents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a	0 900			

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0 900	Continued From page 24 complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and execute a written assisted living contract with the required content for five of five residents (R3, R5, R7, R8, R9). 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: R3 R3 was admitted for services on November 9,	0 900			

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0 900	Continued From page 25 2021. R3's service plan last revised on February 12, 2025, indicated R3 received assistance with medication management, reassurance checks every two to three hours, mobility, transfers with mechanical lift, bathing, dressing/grooming, and laundry. On April 29, 2025, at 9:11 a.m., the surveyor observed unlicensed personnel (ULP)-E, ULP-H, and ULP-I assist R3 transfer from a Broda chair (oversized wheelchair with cushions) to the bed using a full body mechanical lift and provide toileting assistance. R5 R5 was admitted for services on June 4, 2021. R5's [Licensee] Service Agreement-V5 signed December 4, 2024, indicated R5 received assistance with medication management, safety checks, diabetic management including blood glucose checks, dressing/grooming, bathing, and transfers. On April 29, 2025, at 11:50 a.m., the surveyor observed ULP-B check R5's blood glucose. R7 R7 was admitted for services on December 28, 2018. R8 R8 was admitted for services on April 28, 2020. R9 R9 was admitted for services on December 3, 2018.	0 900			

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0 900	Continued From page 26 R's9 service plan last reviewed on August 16, 2024, indicated R9 received assistance with medication management, dressing/grooming, toileting, bathing, and reassurance checks. R3, R5, R7, R8, and R9's [Licensee] Residency Agreement signed November 9, 2021, June 4, 2021, December 28, 2018, April 28, 2020, and December 3, 2018, respectively, which were under the previously held comprehensive home care license. R3, R5, R7, R8, and R9's record lacked a written contract which included all of the terms concerning the provisions of the following as required: (1) housing (2) assisted living services, whether provided directly by the licensee or by management agreement or other agreement; and (3) the resident's service plan, if applicable. In addition, R3, R5, R7, R8, and R9's records lacked evidence the contract had been fully executed as the licensee must: - offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; - give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed; and - the licensee must offer the resident the opportunity to identify a designated representative. On April 30, 2025, at 10:55 a.m., housing director (HD)-C stated she was in the same role back in August 1, 2021, when the comprehensive licensure changed to the assisted living licensure.	0 900			

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0 900	Continued From page 27 HD-C stated the new assisted living contract was not given to R5, R7, and R8 at that time as she was not aware of the requirement. HD-C stated they recently had residents sign new contracts a few weeks ago when they were made aware of the requirement through a survey at their sister facility. HD-C later explained they did not have signed contracts for the above residents but would have them sign it as soon as possible. The licensee's 1.06 Signing an Assisted Living Contract policy dated August 1, 2021, indicated when a prospective resident is ready to sign a lease and move in the assisted living contract will be reviewed, signed, and the original contract will be given to the resident and/or responsible party. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900			
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.	01640			

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01640	Continued From page 28 (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure service plans were authenticated to confirm agreement of the services to be provided 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: On April 29, 2025, at 8:32 a.m., the surveyor observed unlicensed personnel (ULP)-B set up R2's medications and bring them to the television area where R2 was sitting in her wheelchair and administer her medications. R2 was admitted for services on September 6, 2024, and had diagnoses including type 2 diabetes, Parkinsonism (slowed movements, stiffness, and tremors), depression, anxiety disorder, chronic obstructive pulmonary disease,	01640			

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01640	Continued From page 29 and asthma. R2's [Licensee] Service Agreement -V5 signed September 6, 2024, indicated R2 received assistance with safety checks, modified diet, continuous oxygen therapy, medication administration, diabetic management including blood glucose checks, bathing, and dressing and grooming. R2's medical record lacked a service plan with revisions to include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. On April 30, 2025, at 1:30 p.m., clinical nurse supervisor (CNS)-A explained the service plan would be signed by resident/family annually or with a change in condition where services changed. CNS-A did not realize oxygen therapy was listed on R2's signed service agreement and stated that would need to be updated. CNS-A then remembered upon R2's admission, there were orders for oxygen therapy which was why it was added to the service plan, but the oxygen was never received so the order was discontinued. At that time, CNS-A did not have R2 sign a new service agreement. The licensee's 6.10 Service Plan Modifications policy dated July 20, 2021, noted when a resident received assisted living services and a change to the service plan occurred, the service plan must be amended in writing and signed by the resident or the resident's designated representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01640			

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01640	Continued From page 30 (21) days	01640			
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were discarded after the expiration or beyond-use date for two of two residents (R4, R6). 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: R4 diagnoses included Parkinson's Disease. R6 diagnoses included hypertension. R4's service plan with an as of date April 29, 2025, indicated R4 received medication management services including administration and ordering medications.	01890			

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01890	Continued From page 31 The licensee's current resident roster provided during entrance conference on April 28, 2025, indicated R6 received medication management services. On April 29, 2025, at 11:50 a.m., the surveyor observed a medication cart designated for assisted living residents located in the main dining room area and observed unlicensed personnel (ULP)-B administer two tablets of carbidopa-levodopa-25 milligrams (mg)/100 mg per tablet to R4 and check R4's blood glucose. On April 29, 2025, at 12:20 p.m., a review of the medication cart indicated the following medication in-use: -R4's calcium carbonate 500 mg tablet-16 tablets used for heart burn expired February 21, 2025; -R4's gabapentin 100 mg capsule-two capsules used for nerve pain expired March 11, 2025; and -R6's omeprazole 20 mg capsule-28 capsules for stomach acid expired January 17, 2025. On April 29, 2025, at 12:25 p.m., ULP-B stated clinical nurse supervisor (CNS)-A checked the medication cart for expired medications and went to the nursing office and gave CNS-A the expired medications. On April 29, 2025, at 3:30 p.m., CNS-A stated she was responsible for checking for expired medications and her process was to pull out all as needed medications from the medication cart during cycle fill, check for expired medications, then place the back into the cart with the cycle medications. CNS-A could not explain why expired medications were in the medication cart. The licensee's 7.11 Medication Storage policy	01890			

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01890	Continued From page 32 dated July 2021, indicated when medications are managed and stored by licensee, medications would be kept securely locked and stored per manufacturer's directions. Medications would be stored consistent with each resident's medication management plan and service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01960 SS=E	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 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 directed, or to document the reason they were not administered, and any follow up procedures that were provided to meet the resident's needs, for two of two residents (R2, R5) receiving blood glucose monitoring and compression socks (TED). This practice resulted in a level two violation (a	01960			

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01960	Continued From page 33 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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: R2 R2's diagnoses included type 2 diabetes, Parkinsonism (slowed movements, stiffness, and tremors), depression, anxiety disorder, chronic obstructive pulmonary disease, and asthma. R2's [Licensee] Service Agreement -V5 signed September 6, 2024, indicated R2 received assistance with safety checks, modified diet, medication administration, diabetic management including blood glucose checks, bathing, and dressing and grooming. R2's hospital discharge orders electronically signed on April 1, 2025, ordered blood glucose monitoring twice daily. R2's [Licensee] Assessment and ISP-V3 (post-hospital assessment) dated April 3, 2025, indicated R2 required assistance for insulin and blood sugar management, but indicated "no-resident is independent" for frequency of staff performing blood glucose checks. R2's record lacked evidence of blood glucose check results as they were not transcribed by clinical nurse supervisor (CNS)-A. On April 30, 2025, at 11:49 a.m., CNS-A stated	01960			

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01960	Continued From page 34 R2 was on weekly insulin then discontinued by the primary provider prior to the recent hospitalization. The hospital discharge orders restarted weekly insulin which she implemented but not the blood glucose checks. On April 30, 2025, at 1:30 p.m., CNS-A stated she notified R2's primary provider of the hospital orders on the online portal and did not hear back from the provider. The primary provider completed an on-site visit with R2 in person on April 21 or 22, but CNS-A stated she did not ask for clarification at that time. CNS-A stated she sent the primary provider a message on the portal for clarification that day. R5 R5's diagnoses included bipolar disorder (extreme mood swings including manic and major depression), chronic pain, osteoarthritis, type 2 diabetes, sleep disorders, and chronic obstructive pulmonary disease (COPD). R5's [Licensee] Service Agreement-V5 signed December 4, 2024, indicated R5 received assistance with medication management, safety checks, diabetic management including blood glucose checks, TED sock application, dressing/grooming, bathing, and transfers. R5's provider orders signed January 16, 2025, did not include TED socks. During observation and interview on April 30, 2025, at 12:35 p.m., the surveyor observed R5 sitting in her power wheelchair within her room. The surveyor asked R5 if she wore her compression socks and she pulled up her pants and said no she had not worn them for a long time and because of that, staff had stopped	01960			

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01960	Continued From page 35 asking her if she wanted to wear them. R5 explained she did have the socks available. The surveyor observed R5's right leg to be slightly swollen. R5 then explained by the end of the day, her legs would be swollen. R5's task record dated April 1-30, 2025, indicated initials daily at 7:00 a.m. and 7:00 p.m. except April 6, 2025, at 7:00 a.m. which was left blank. On April 30, 2025, at 10:39 a.m., under TED sock task instructions, it indicated the following: 1. Task completed? Yes. During interview on April 30, 2025, at 1:00 p.m., the surveyor approached and asked unlicensed personnel (ULP)-F on R5's April 2025 task record if the initials "MML" at 10:39 under "TED HOSE: Requires Assistance," were hers and she stated "yes." ULP-F explained if there were initials on the task record, it meant the task was completed. The surveyor asked if the TED socks were applied today, she said they were not. ULP-F then stated she worked with R5 a lot and R5 had been consistently refusing the TED socks and would indicate "no" or "refused" but ULP-F was unsure where the surveyor could find that documentation. ULP-F was also unsure if the nurse was made aware of R5's TED sock refusals. During interview on April 30, 2025, at 1:30 p.m., CNS-A stated ULP-F's initials on the task record indicated the TED socks were applied and ULP's have the option to document refused so CNS-A stated ULP-F did not chart that R5 refused the TED sock. The licensee's 7.16 Medication & Treatment Orders-Implementing policy dated July 2021, indicated medication and treatment/therapy	01960			

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01960	Continued From page 36 orders received must be implemented within 24 hours of receipt. The licensee's 2.37 Resident Record-Documentation policy dated July 19, 2021, indicated the licensee would create and maintain a correct and accurate treatment/therapy record for each resident receiving treatments and therapies. The policy directed documentation in the resident's record after providing the treatment, including the date, time, method of administration, and a signature and title of the authorized staff who provided the treatment/therapy. In addition, the policy indicated, when medications, services, treatments, or therapies are not performed per the service agreement and schedule, staff must document the reason why it was not performed or administered. Tasks not performed or administered must be reported and followed up on to meet the resident's needs. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960			
02310 SS=E	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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	02310			

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02310	Continued From page 37 review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for two of three residents (R3, R5) with hospital-style bed rails. 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: R3 R3 was admitted for services on November 09, 2021, and had diagnosis including dementia, type 2 diabetes, muscle weakness, and osteoarthritis (joint pain). R3's service plan last revised on February 12, 2025, indicated R3 received assistance with medication management, reassurance checks every two to three hours, mobility, transfers with mechanical lift, bathing, dressing/grooming, and laundry. On April 29, 2025, at 9:11 a.m., the surveyor observed unlicensed personnel (ULP)-E, ULP-H, and ULP-I (trainee observing) assist R3 transfer from a Broda chair (oversized wheelchair with cushions) to the bed from the right side with bilateral bed rails (left bed rail was raised and right was lowered), using a full body mechanical lift and provided toileting assistance. Once completed, the surveyor observed the right upper	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33954	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/01/2025
NAME OF PROVIDER OR SUPPLIER SUITE LIVING OF ROSEVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 197 COUNTY ROAD B2 WEST ROSEVILLE, MN 55113			
(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
02310	Continued From page 38 bed rail to be "wobbly" by rocking back and forth from side to side and pulled away from the bed slightly. The left upper bed rail was secured. R3's Weekly Bed Rail Inspection/Assessment completed by clinical nurse supervisor (CNS)-A on April 24, 2025, indicated R3 had hospital-style bed rails (2), manufacturer's guideline was included in the bed rail assessment binder, and that the bed rails were tightened per manufacturer's guideline and inspected. R3's Bed Rail Assessment-V3-Copy-V7 completed on October 4, 2024, included the following information: -assessment of resident's cognitive and physical status as they pertain to bed rail to determine the intended purpose of the bed rail and whether the resident is at high risk for entrapment; -installation and use according to manufacturer's guidelines; -documented evidence to indicate the licensee had checked the consumer product safety commission (CSPC) website for bed rail recalls; and -entrapment zone measurements. R3's record included the following: -Bed Rail Disclaimer dated May 13, 2022; -manufacturer description of the bed rail; -photo of the bed rail measurements from within the bed rail; and -entrapment zones documented on May 18, 2023. R3's record lacked an assessment of bed rails with each 90-day assessment. R5 R5 was admitted for services on June 4, 2021,	02310			

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02310	Continued From page 39 and had diagnosis including bipolar disorder (extreme mood swings including manic and major depression), chronic pain, osteoarthritis, type 2 diabetes, sleep disorders, and chronic obstructive pulmonary disease (COPD). R5's [Licensee] Service Agreement-V5 signed December 4, 2024, indicated R5 received assistance with medication management, safety checks, diabetic management including blood glucose checks, dressing/grooming, bathing, and transfers. On April 29, 2025, at 2:15 p.m., the surveyor observed R5's unoccupied hospital bed with both upper T-style half rails raised. R5's Weekly Bed Rail Inspection/Assessment completed by CNS-A on April 24, 2025, indicated R5 had hospital-style bed rails (2), manufacturer's guideline was included in the bed rail assessment binder, and that the bed rails were tightened per manufacturer's guideline, and inspected. R5's Bed Rail Assessment-V3-Copy-V7 dated August 14, 2024, included the following information: -assessment of resident's cognitive and physical status as they pertain to bed rail to determine the intended purpose of the bed rail and whether the resident is at high risk for entrapment; -installation and use according to manufacturer's guidelines; -documented evidence to indicate the licensee had checked the CSPC website for bed rail recalls; and -entrapment zone measurements. R5's record included the following: -Bed Rail Disclaimer dated May 13, 2022;	02310			

Minnesota Department of Health

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02310	Continued From page 40 -manufacturer description of the bed rail; -photo of the bed rail measurements from within the bed rail; and -entrapment zones documented on May 18, 2023. R5's record lacked an assessment of bed rails with each 90-day assessment. During interview and observation on April 29, 2025, at 11:30 a.m., CNS-A explained the facility had three residents with hospital-style bed rails. She stated they had the bed rail manual, she checked for tightness and will tighten the bed rails if needed, then every three months, would obtain measurements of the entrapment zones. The surveyor asked if R3's bed rail was ever "wobbly," she did not recall. The surveyor and CNS-A went to R3's room where CNS-A rocked the bed rail back and forth and pull away from the bed slightly. CNS-A stated she did not recall it being "that bad," and would need to contact hospice (end of life services) to get it fixed. During interview on April 29, 2025, at 2:00 p.m., the surveyor requested the bed rail binder from CNS-A. CNS-A stated the bed rail assessments would be in each resident's online health record (PointClickCare-PCC) labeled as "***bed rail assessment" as she completed that assessment quarterly. During interview at 3:00 p.m., CNS-A stated she did not complete bed rail assessments for R3 and R5 recently. She explained PCC did not prompt her to complete them, but she was prompted to complete the weekly bed rail inspection. She knew the assessments needed to be completed quarterly but they did not get done. CNS-A was shown where to locate bed rail documentation	02310			

Minnesota Department of Health

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02310	Continued From page 41 requirements on the Minnesota Department of Health (MDH) website. The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The MDH website, Assisted Living Resources & Frequently Asked Questions (FAQs) last updated December 13, 2024, indicated the need for assistive devices, such as bed rails, must be assessed upon initial installation, with each 90-day assessment and change of condition. (Please refer to Rule 4659.0150 where it directs assessment of mobility, including ambulation, transfers, and assistive devices.) The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed	02310			

Minnesota Department of Health

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02310	Continued From page 42 without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, documentation about a resident's hospital bed rail should include, but is not limited to: -Purpose and intention of the bed rail; -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; and -Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. Assisted Living Facilities: Minnesota Rules Chapter 4659.0150 Subpart 2. Assessment tool elements B. (3) indicated a resident's mobility status must be assessed to include ambulation, transfers, and assistive devices. The licensee's 6.28 Side Rails policy revised May 10, 2023, read: -continued use of physical devices will be assessed at least every 90 days or with significant change to determine if the device is still needed to enhance the resident's safety and/or bed mobility; -an inspection of all rooms and side rails will be done weekly. If a side rail is present, the side rail will be checked to make sure it is in good working order and the nurse will tighten the side rail as tightly as possible; and -if the side rails have become loose/unstable in any way it will be tightened as tightly as possible, if unable to tighten to a safe level that does not change the initial measurements and/or the side	02310			

Minnesota Department of Health

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02310	Continued From page 43 rail is determined to be unsafe, it will be removed and the resident/resident's representative will be notified. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	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

Page: 1

Establishment Info

Suite Living of Roseville
197 County Road B2 West
Roseville, MN 55113
Ramsey County
Parcel:

Phone:

License Info

License: HFID 33954

Risk:
License:
Expires on:
CFPM: Dana B
CFPM #: 114857; Exp: 10/28/2025

Inspection Info

Report Number: F1025251001
Inspection Type: Full - Single
Date: 4/28/2025 Time: 11:30 AM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery: Emailed

! New Order: 3-500D Microbial Control: disposition of food

3-501.18A Priority Level: Priority 1 CFP#: 23

MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.

COMMENT: Deli ham in upright cooler date marked from April 18. Discard. If items are frozen and thawed, update the date mark to effectively track how long the product has been opened and how many days of the seven remain from first opened. Ham discarded.

Comply By: Complied On Site Originally Issued On: 4/28/2025

New Order: 4-200 Equipment Design and Construction

4-203.13 Priority Level: Priority 3 CFP#: 48

MN Rule 4626.0563 Replace the pressure gauge on the dishwasher with one that is accurate to 2 PSI in the range indicated on the manufacturer's data plate the 15 to 25 PSI range.

COMMENT: Rinse pressure gauge on dish machine non operational during inspection, read zero during rinse cycle. Calibrate, repair, or replace gauge

Comply By: 5/9/2025 Originally Issued On: 4/28/2025

Food & Beverage General Comment

Discussed date marking, product rotation, breakfast (cold breakfast majority served), employee health and hygiene
Eggs Pasteurized, shell or liquid
Food TMD and min/max available for dish machine, test for at least 160 deg F max contact temperature

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 F1025251001 from 4/28/2025

Dana


Casey Kipping, MA RS
Public Health Sanitarian 3
651-201-4513
casey.kipping@state.mn.us

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Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Page: 1

Establishment Info

Suite Living of Roseville
Roseville
County/Group: Ramsey County

Inspection Info

Report Number: F1025251001
Inspection Type: Full
Date: 4/28/2025
Time: 11:30 AM

New Record: Product/Item/Unit: Ham; **Temperature Process:**

Location: Upright Refrigerator at 41 Degrees F.

Comment:

Violation Issued?: No

New Record: Product/Item/Unit: Soup; **Temperature Process:** Hot-Holding

Location: Steam Table at 155 Degrees F.

Comment:

Violation Issued?: No



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Sanitizer Observations/Recordings

Page: 1

Establishment Info

Inspection Info

Suite Living of Roseville
Roseville
County/Group: Ramsey County

Report Number: F1025251001
Inspection Type: Full
Date: 4/28/2025
Time: 11:30 AM

New Record: **Product:** Hot Water; **Sanitizing Process:** High Temp Dishwasher

Location: Dishwashing Area **Equal To**

Comment: 180 F rinse

160 F contact

Violation Issued?: No

New Record: **Product:** Acid Based; **Sanitizing Process:**

Location: 3-Compartment Sink **Equal To**

Comment: OK

Violation Issued?: No

Minnesota (MDH) Version EH Manager; RPT: F1025251001		Food Establishment Inspection Report		Page 1 of 1		
DEPARTMENT OF HEALTH Metro District Office Minnesota Department of Health 625 Robert St N, PO BOX 64975 St Paul, MN 55164		No. of Risk Factor/Intervention/Violations		1	Date: 4/28/2025	
		No. of Repeat Risk Factor/Intervention/Violations			Time: 11:30 AM	
		Score (optional)			Dur: min	
Establishment: Suite Living of Roseville		Address: 197 County Road B2 West		City/State: Roseville, MN	Zip: 55113	Phone:
License/Permit #: HFID 33954		Permit Holder:		Purpose of Inspection: Full	Est. Type:	Risk Category:
FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS						
Designated compliance status (IN, OUT, N/O, N/A) for each numbered item						
IN=in compliance OUT=not in compliance N/O=not observed N/A=not applicable						
Mark "X" in appropriate box for COS and/or R						
COS=corrected on-site during inspection R=repeat violation						
Compliance Status				COS	R	
Supervision						
1	IN	Person in charge present, demonstrate knowledge and performs duties				
2	IN	Certified Food Protection Manager				
Employee Health						
3	IN	knowledge, responsibilities, and reporting				
4	IN	Proper use of restriction and exclusion				
5	IN	Response to vomiting, diarrheal events				
Good Hygienic Practices						
6	IN	Proper eating, tasting, drinking, tobacco use				
7	IN	No discharge from eyes, nose, and mouth				
Preventing Contamination by Hands						
8	IN	Hands clean and properly washed				
9	IN	No bare hand contact with RTE foods, alternatives				
10	IN	Adequate handwashing sinks supplied and access				
Approved Source						
11	IN	Food obtained from approved source				
12	N/O	Food Received at proper temperature				
13	IN	Food in good condition, safe & unadulterated				
14	N/A	Records available: shellstock tags, parasite dest.				
Protection From Contamination						
15	IN	Food separated and protected				
16	IN	Food-contact surfaces; cleaned & sanitized				
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food				
GOOD RETAIL PRACTICES						
Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.						
Mark "X" or OUT 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						
Compliance Status				COS	R	
Safe Food and Water						
30	IN	Pasteurized eggs used where required				
31		Water & ice from approved source				
32	N/A	Variance obtained for specialized processing methods				
Food Temperature Control						
33		Proper cooling methods used; adequate equipment for temperature control				
34	N/O	Plant food properly cooked for hot holding				
35	N/O	Approved thawing methods used				
36		Thermometers provided & accurate				
Food Identification						
37		Food properly labeled; original container				
Prevention of Food Contamination						
38		Insects, rodents, & animals not present; no unauthorized person				
39		Contamination prevented during food prep, storage, & display				
40		Personal cleanliness				
41		Wiping cloths: properly used & stored				
42		Washing fruits & vegetables				
Person in Charge (signature)						
Inspector (signature)						
Follow-up: Follow-up Date:						
Time/Temperature Control for Safety						
18	N/O	Proper cooking time & temperatures				
19	N/O	Proper reheating procedures for hot holding				
20	N/O	Proper cooling time and temperature				
21	IN	Proper hot holding temperatures				
22	IN	Proper cold holding temperatures				
23	OUT	Proper date marking & disposition	X			
24	N/A	Time as public health control;procedures & record				
Consumer Advisory						
25	N/A	Consumer advisory provided for raw or undercooked foods				
Highly Susceptible Populations						
26	IN	Pasteurized foods used; prohibited foods not offered				
Food/Color Additives and Toxic Substances						
27	N/A	Food additives; approved & properly used				
28	N/A	Toxic substances properly identified;stored;used				
Conformance with Approved Procedures						
29	N/A	Compliance with variance, specialized processes & HACCP plan				
Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health interventions are control measures to prevent foodborne illness or injury						