DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

August 24, 2022

Administrator
Suite Living Of Little Canada
2740 Rice Street
Saint Paul, MN 55113

RE: Project Number(s) SL34744015

Dear Administrator:

On August 9, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the May 11, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

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

PMB

Electronically Delivered

June 27, 2022

Administrator
Suite Living Of Little Canada
2740 Rice Street
Saint Paul, MN 55113

RE: Project Number(s) SL34744015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on May 11, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

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

St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services = $3,000

The total amount you are assessed is $3,000. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

Please address your cover letter for general reconsideration requests to:	Free from Maltreatment reconsideration requests should be addressed to:

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

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

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

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

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

Sincerely,

Jonathan Hill, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34744	A. BUILDING: _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING OF LITTLE CANADA	2740 RICE STREET SAINT PAUL, 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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34744015 On May 09, 2022 through May 11, 2022 the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 28 residents receiving services under the provider's Assisted Living with Dementia Care license. On May 09, 2022, at 5:30 p.m. an immediate correction order was written at 2310. On May 10, 2022, at 1:57 p.m. the immediacy was removed, the scope and level remain the same.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living facilities with Dementia Care. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 110	Continued From page 1	0 110		
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's 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 the residents). The findings include: On May 09, 2022, at 11:30 a.m.regional director of operations (RD)-E identified as LALD for the licensee. RD-E obtained an assisted living director license on July 16, 2021. On May 09, 2022, at 11:30 a.m., the Board of Executives for Long-Term Services and Support (BELTSS) website, indicated RD-E held a current assisted living director license. The BELTSS	0 110		

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0 110	Continued From page 2 website did not indicate RD-E was listed as the Director of Record for the licensee. On May 11, 2022, at 2:00 p.m., RD-E confirmed they were not listed as the Director of Record for licensee and would contact BELTSS for correction. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota	0 480		

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0 480	Continued From page 3 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated May 09,2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to ensure an individual abuse prevention plan was developed to include the required content for one of three residents (R1)	0 630		

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0 630	Continued From page 4 with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R7's diagnoses included dementia, insomnia, diabetes, hypertension and chronic kidney disease. R7's record lacked individualized abuse prevention plans to include statements of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On May 11, 2022, at 11:45 a.m. a regional director of nursing (RDON)-A verified R7's record did not include an individual abuse prevention plan (IAPP) with the required content. RDON- A stated she expected nurses to complete the IAPP for each resident, however R7's individual abuse prevention plan was missed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		

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0 650	Continued From page 5	0 650		
0 650 SS=A	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content for one of two	0 650		

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0 650	Continued From page 6 unlicensed personnel (ULP)- B with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-B had a start date of April 22, 2020. On May 10, 2022, at 9:00 a.m. ULP-B was observed providing peri care, catheter care, and repositioning for R5. ULP-B's employee record lacked evidence of documentation of an annual performance review that identified areas of improvement needed and training needs. On May 11, 2022, at 12:30 p.m. the housing director (HD)-D verified ULP-B's record lacked evidence of an annual performance review. HD-D stated she expected an annual performance review to be completed in in ULP-B's chart within one year from hire date. The licensee's Assisted Living License Resource Manual, dated July 20, 2021, Employee Evaluation indicated reads "all staff of Suite Living would be given an employee evaluation at least annually". No further information was provided.	0 650		

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0 650	Continued From page 7 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: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must 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 comply with the minimum frequency of inspection, maintenance, and test requirements for the facility's emergency power	0 680		

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0 680	Continued From page 8 system (permanent generator) as part of the facility's emergency disaster and preparedness plan as required under Minnesota Rules, Part 4659.0100. This had the potential to affect the current resident receiving services under the assisted living license, as well any staff and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), 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 May 10, 2022, at approximately 11:00 a.m., survey staff asked about the standby emergency power generator and related inspection and testing records from the regional director of operations (RD)-E. At approximately 11:20 a.m. during the facility tour with the RD-E, the RD-E and survey staff received a phone call from their maintenance staff to notify us that they did not know that testing and inspections of the standby generator were required, but will take care of those in the future. On May 10, 2022, at approximately 11:20 a.m., the licensee failed to provide the minimum frequency of inspection and test requirements for the emergency power generator as outlined under NFPA 110, (as referenced under the Code of Federal Regulations, title 42, section 483.73) to ensure proper performance of the generator. The RD-E verified the findings.	0 680		

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0 680	Continued From page 9 WEEKLY INSPECTIONS No documentation or records were provided to support weekly inspections. MONTHLY GENERATOR LOAD TESTS No documentation or records were provided to support generator load tests. MONTHLY TRANSFER SWITCH OPERATION TESTS No documentation or records were provided to support monthly transfer switch operation tests. On May 10, 2022, at approximately 2:00 p.m., the housing director-D acknowledged the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 680		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall	0 810		

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0 810	Continued From page 10	0 810		

receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.
(d) Fire safety and evacuation plans shall be readily available at all times within the facility.
(e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.
(f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.

This MN Requirement is not met as evidenced by:
Based on document review and interview, the licensee failed to provide all required content on the fire safety and evacuation plan, evacuation drills, and employee training on fire safety and evacuation. This has the potential to directly affect the safety of visitors, staff, and all residents receiving care.

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 May 10, 2022, at approximately 12:30 p.m., survey staff reviewed the facility's fire safety and evacuation plan, drill, and training documentation.

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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
0 810	Continued From page 11 Documentation review indicated the following: FIRE SAFETY and EVACUATION PLAN -The fire safety and evacuation plan, policy documents 9.06 and 9.07, dated July 20, 2021, lacked procedures for addressing resident movement and evacuation that included unique or unusual resident-specific needs during a fire or similar emergency evacuation. Unique situations may be residents who are ambulatory or non-ambulatory such as wheelchair-bound, on walkers, bedridden, cognitive deficit, and needing assistance that must be addressed in the plan. -The fire safety and evacuation plan, policy documents 9.06 and 9.07, dated July 20, 2021, lacked fire protection procedures for residents . TRAINING The policy documents 9.06 and 9.07, dated July 20, 2021, showed the correct frequency of employee training on the fire safety and evacuation plan was adopted but the licensee lacked records to substantiate employee training on the fire safety and evacuation plan had been completed. FIRE AND EVACUATION DRILLS The policy documents 9.06 and 9.07, dated July 20, 2021, showed the correct minimum number of fire and evacuation drills to be performed as required but the licensee lacked records to substantiate that the minimum frequency of employee training on the fire safety and evacuation plan had been completed. The last record of drill performed was dated April 6, 2022, at 2:08 p.m., and other drill forms were blank. On May 10, 2022, at approximately 1:45 p.m., the HD-D acknowledged the findings during the exit interview. The HD-D stated that they received the	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34744	A. BUILDING: _____ B. WING _____	05/11/2022

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0 810	Continued From page 12 drill forms at the end of March (2022) to start performing the drills. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 810		
0 970 SS=F	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident, with seven of seven residents (R1, R2, R3, R4, R5, and R7) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	0 970		

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0 970	Continued From page 13 The findings include: On May 10, 2022, at 9:00 a.m. regional director of nursing (RDON)-A provided Bed Rail Disclaimer which indicated the licensee was not liable for injury, entrapment, or death related to the use of the bedrails. The Bed Rail Disclaimer dated May 09, 2022, for R1, R2, R3, R4, and R5 contained language waiving liability indicated the licensee was not liable for injury, entrapment, or death related to the use of the bedrails. On record review, Assisted Living with Dementia License Agreement dated: January 28, 2022, for R7; February 2, 2022, for R5 and Residency Agreement Data Sheet dated September 26, 2019, for R1 contained language waiving liability indicated " Management is not liable to Resident or Resident's guest for any injury, death or property damage occurs the result of equipment malfunction or hazardous conditions with the building". On May 10, 2022, at 12: 45 p.m. RDON-A confirmed resident's Bed Rail Disclaimer included language which waived liability of the licensee. Also, Housing director (HD)-D verified resident's Assisted Living Contract/ Residency Agreement Data Sheet included language which waived liability of the licensee. HD-D confirmed language with waiver of liability was included in every resident's record within their respected assisted living contract. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		

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0 970	Continued From page 14 R5's Suite Living/ Assisted Living with Dementia Licence Agreement, signed February 2, 2022, contained language waiving liability indicated " Provider is not liable to Resident or Resident's guest for any injury, death or property damage occurs the result of equipment malfunction or hazardous conditions with the building" under subtitle "No Liability of Management.	0 970		
01420 SS=D	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If an unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted training and competency evaluations for one of one unlicensed personnel (ULP)-B who performed delegated tasks. This practice resulted in a level two violation (a	01420		

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01420	Continued From page 15 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 problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-B was hired on April 22, 2020, to provide direct care services to residents of the facility. On May 10, 2022, at 9:00 a.m. ULP-B was observed providing peri care, catheter care, and repositioning for R5. ULP-B's employee record lacked documentation to indicate ULP-B received training and demonstrated competency for catheter care practices. On May 10, 2022, at 12:45 p.m. the regional director, (RD)-A, confirmed ULP-B did not complete the licensee's "Educate Demo Skill Assessment for Catheter Care, dated 2007". RD-A stated an RN was expected to train and provide a skills demonstration assessment for any ULP who provided these tasks to a resident within 30 days of the start of their employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01420		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment	02040		

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02040	Continued From page 16 An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the licensee failed to provide a complete facility hazard vulnerability or safety risk assessment (HVA) plan to identify hazard vulnerabilities and mitigations on and around the property. This has the potential to directly affect all memory care residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). The findings include: On May 10, 2022, between the hours of 10:50 a.m. and 12:20 p.m., survey staff toured the facility with the regional director of operations (RD)-E. The RD-E advised survey staff to	02040		

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02040	Continued From page 17 connect with the housing director (HD)-D with questions and left the building immediately after the tour at approximately 12:20 p.m. On May 10, 2022, at approximately 12:30 p.m., survey staff reviewed the facility's HVA plan documentation. A review of the documentation indicated the licensee lacked a complete HVA plan to identify and mitigate local site-specific hazard vulnerabilities and mitigations on and around the property. An HVA plan must include documentation on all potential site-specific hazard vulnerabilities and mitigations inside and outside the property such as potential resident elopement for the delayed egress doors, active exit-seeking residents who may follow a visitor through a secured door or compromised window hardware, busy local roads, misuse of portable fire extinguishers or accessories, or access to an appliance such as the toaster located in the common area that may lead to resident harm must be identified, assessed, and mitigated in the plan. On May 10, 2022, at approximately 1:45 p.m., survey staff explained to the HD-D that the licensee must develop a complete HVA plan documenting both hazard vulnerabilities and mitigations for this facility. The HD-D acknowledged the findings during the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14)	02040		
02170 SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA	02170		

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02170	Continued From page 18 (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the	02170		

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02170	Continued From page 19 licensee failed to have an evaluation for an activity plan for two of three residents (R5, R7) who received services under an assisted living with dementia care license. 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 problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R5 and R7's records lacked an activity plan to include all required content. R5's diagnoses included, but were not limited to, diabetes mellitus, atrial fibrillation (an irregular often fast heart rate), diabetes mellitus, alcohol dependence, anxiety, essential tremor, insomnia, obstructive sleep apnea and lymphedema. R7's diagnoses included, but were not limited to, diabetes mellitus, hypertension, and wheezing. R5 and R7's record lacked evidence the resident had been evaluated for activities according to the licensing rules of the facility, to include the following: - past and current interests; - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions.	02170		

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02170	Continued From page 20 In addition, R5 and R7's record lacked the development of an individualized activity plan. On May 11, 12:16 p.m., the activities director (AD)-F confirmed the licensee had not completed an activity evaluation or developed a plan for R5 and R7. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		
02310 SS=I	144G.91 Subd. 4 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 review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for five of five residents (R1, R2, R3, R4, R5) who utilized bed rails with records reviewed. This resulted in an immediate correction order on May 9, 2022, at approximately 5:30 p.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems	02310		

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02310	Continued From page 21	02310		

are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

R1, R2, R3, R4, and R5 side rails lacked consistent documented evidence of measuring the zones of entrapment, registered nurse (RN) assessment of the side rails, and education of the risks and benefits associated with the use of siderails.

On May 09, 2022, at 1:27 p.m. during the tour of the licensee, the following was observed:
- R1 was observed to have a half bedrail on the left side of the bed.
- R2 was observed to have bilateral bedrails.
- R3 was observed to have full rails in the raised position bilaterally.
- R4 was observed to have bilateral "U" shaped bedrails. The bed rail was not affixed to the bed frame and was loosely under the mattress.
- R5 was observed in bed with two half rails in the raised position.
At the time of the observations, registered nurse-(RN)-A stated R1, R3, and R4 lacked siderails assessment and measurement. RN-A verified R2 and R5 lacked documentation of a siderail assessment, and education of the risks and benefits associated with the use of siderails, and measurements of the siderails.

R1's medical record lacked documentation of a siderail assessment, education of the risks and benefits associated with the use of siderails, and measurements of the siderails. R1 had diagnoses to include hypertension and chronic kidney disease, and received services to include medication administration, dressing, grooming

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02310	Continued From page 22 and mobility. R2's medical record lacked documentation of a measurements of the siderails, education of the risks and benefits associated with the use of siderails, and measurements of the siderails. The siderail assessment dated June 6, 2021. R2 had diagnoses to include Diabetes and Insomnia, and received services to include medication administration, dressing, toileting, and mobility R3's medical record lacked documentation of a measurements of the full length siderails, education of the risks and benefits associated with the use of siderails, and measurements of the siderails. R3 had diagnoses to include sleep apnea, and received services to include medication administration, dressing, toileting, and mobility R4's medical record lacked documentation of a siderail assessment, education of the risks and benefits associated with the use of siderails, and measurements of the siderails. The surveyor grasped the siderail and noted the siderail not secured to the bed and did move when pulled and pushed on with force. R4 had diagnoses to include bipolar and insomnia, and received services to include medication administration, dressing, toileting, and mobility R5 had diagnosis to include diabetes mellites and anxiety. R5's service plan indicated the resident required assistance with grooming, dressing and mobility. The "Zoning in On Bed Dangers Safety Measures sheet, dated January 31, 2022, indicated R5 had bilateral half bedrails placed upper half of the bed and were measured in zone one at two inches and zone three at threes inches. The document lacked measurements in	02310		

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02310	Continued From page 23 zones 2,4,5,6, and 7. The Food and Drug Administration (FDA) "A Guide to Bed Safety" revised April 2010, included the 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 licensee's Policy for bedrails dated July 20, 2021, indicated "Suite Living will assess the use, educate the resident risk and benefits of side rails, and verify that the side rail in use is of a safe design and utilized consistent with manufacturer's direction". No further information provided. TIME PERIOD FOR CORRECTION: Immediate On May 10, 2022, the immediacy was removed, the scope and level remain the same.	02310		

Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
Saint Paul
651-201-4500

Type: Full
Date: *05/09/22*
Time: 12:14:04
Report: 1018221064

Food and Beverage Establishment Inspection Report

Location:
Suite Living Of Little Canada
2740 Rice Street
Little Canada, MN55113
Ramsey County, 62

Establishment Info:
ID #: 0037573
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6514240130
ID #:

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

The following orders were issued during this inspection.

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.12G

MN Rule 4626.0275G Store the bulk food dispensing utensil in the food with the handle extending out of the food, or in a protective enclosure attached or adjacent to the enclosure with the utensil on a tether of easily cleanable material which is short enough to prevent the utensil from making contact with the floor.

SCOOP FOR ICE MACHINE WAS OBSERVED TO BE STORED IN THE ICE. COMPLY WITH RULE.

Comply By: 05/09/22

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: BUCKET
Violation Issued: No

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: BUCKET
Violation Issued: No

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: 3 COMPARTMENT SINK
Violation Issued: No

Hot Water: = at 170 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding/ HAM
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: Cold Holding/ MELON
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: Cold Holding/ PEPPERONI
Temperature: 40 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: Cold Holding/ POTATO SALAD
Temperature: 38 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: Cooking/ POTATOES
Temperature: 170 Degrees Fahrenheit - Location:
Violation Issued: No

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

DISCUSSED EMPLOYEE ILLNESS.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

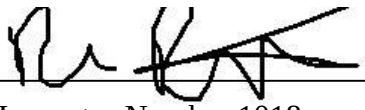
I acknowledge receipt of the Minnesota Department of Health inspection report number 1018221064 of 05/09/22.

Certified Food Protection Manager: JENNIFER MATHE

Certification Number: FM20955 Expires: 07/19/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
JENNIFER MATHE
KITCHEN MANAGER

Signed: 
Inspector Number 1018

6512014500

Report #: 1018221064

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
Saint Paul

No. of RF/PHI Categories Out	0	**Date**	05/09/22
No. of Repeat RF/PHI Categories Out	0	**Time In**	12:14:04
Legal Authority MN Rules Chapter 4626		**Time Out**	

	Address	**City/State**	**Zip Code**	**Telephone**
Suite Living Of Little Canada	2740 Rice Street	Little Canada, MN	55113	6514240130

License/Permit #	**Permit Holder**	**Purpose of Inspection**	**Est Type**	**Risk Category**
0037573		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

Compliance Status		COS	R
Supervision			
1 IN OUT	PIC knowledgeable; duties & oversight		
2 IN OUT N/A	Certified food protection manager, duties		
Employee Health			
3 IN OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4 IN OUT	Proper use of reporting, restriction & exclusion		
5 IN OUT	Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices			
6 IN OUT N/O	Proper eating, tasting, drinking, or tobacco use		
7 IN OUT N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands			
8 IN OUT N/O	Hands clean & properly washed		
9 IN OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10 IN OUT	Adequate handwashing sinks supplied/accessible		
Approved Source			
11 IN OUT	Food obtained from approved source		
12 IN OUT N/A N/O	Food received at proper temperature		
13 IN OUT	Food in good condition, safe, & unadulterated		
14 IN OUT N/A N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination			
15 IN OUT N/A N/O	Food separated and protected		
16 IN OUT N/A	Food contact surfaces: cleaned & sanitized		
17 IN OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status		COS	R
Time/Temperature Control for Safety			
18 IN OUT N/A N/O	Proper cooking time & temperature		
19 IN OUT N/A N/O	Proper reheating procedures for hot holding		
20 IN OUT N/A N/O	Proper cooling time & temperature		
21 IN OUT N/A N/O	Proper hot holding temperatures		
22 IN OUT N/A	Proper cold holding temperatures		
23 IN OUT N/A N/O	Proper date marking & disposition		
24 IN OUT N/A N/O	Time as a public health control: procedures & records		
Consumer Advisory			
25 IN OUT N/A	Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations			
26 IN OUT N/A	Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances			
27 IN OUT N/A	Food additives: approved & properly used		
28 IN OUT	Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures			
29 IN OUT N/A	Compliance with variance/specialized process/HACCP		

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 05/09/22

Inspector (Signature)