Electronically Delivered

November 14, 2024

Licensee
Suite Living Senior Care of Lakeville, LLC
20949 Keokuk Avenue
Lakeville, MN 55044

RE: Project Number(s) SL39344015

Dear Licensee:

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

The Minnesota Department of Health completed an initial survey on October 10, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

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

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

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

The correction order documentation should include the following:

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

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

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

A state correction 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.

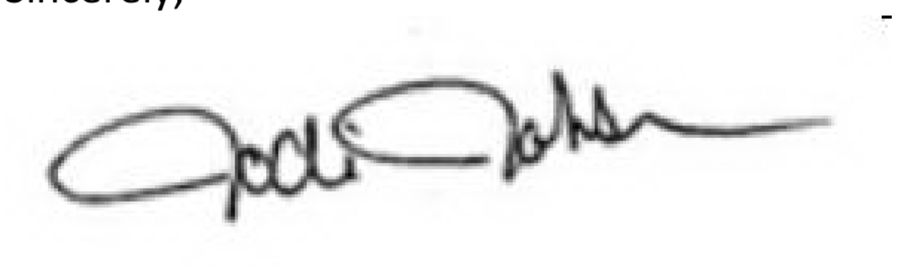
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

If you have any questions, please contact me.

Sincerely,



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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39344	A. BUILDING: _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SENIOR CARE OF LAKEVILLE L	20949 KEOKUK AVENUE LAKEVILLE, MN 55044

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL39344015-0 On October 7, 2024, through October 10, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 26 residents; 26 receiving services under the provisional 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 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (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 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 October 7, 2024, 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	0 630		

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0 630	Continued From page 2 person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of three residents (R1 and R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 R1's diagnoses that included chronic respiratory failure and diabetes. R1's service agreement dated June 21, 2024, indicated R1 received services to include grooming, dressing, bathing, toileting, transfers, ambulation, repositioning, safety checks, ace wraps/stockings, housekeeping, laundry, meals, medication administration, diabetic management, and oxygen therapy.	0 630		

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0 630	Continued From page 3 On October 7, 2024, at 11:44 a.m., the surveyor observed unlicensed personnel (ULP)-C apply compression stockings to R1's lower extremities. R1's IAPP dated September 20, 2024, identified the following areas of vulnerability: -is not oriented to person, place, and time -environment is not always safe/clean -has a diagnosis of cognitive communication deficit -unable to understand and/or follow instructions -is not able to ambulate safely with/without devices -resident has chronic conditions, pain, illness, disability -not able to summon assistance/call for help by using call light or telephone -unable to manage finances -falls or frequent bruising -has side rails/bed mobility device(s) -unable to report abuse/neglect/exploitation -resident susceptible to abuse from another individual, including other vulnerable adults -resident at risk of abusing other vulnerable adults -resident at risk of self -abuse R1's IAPP did not include specific interventions for the identified vulnerabilities as required. R3 R3 was admitted on January 30, 2024, with diagnoses that included dementia. R3's service agreement dated January 30, 2024, indicated R3 received services to include grooming, dressing, bathing, toileting, transfers, ambulation, repositioning, safety checks, ace wraps/stockings, housekeeping, laundry, meals, and medication administration.	0 630		

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0 630	Continued From page 4 On October 8, 2024, at 9:11 a.m., the surveyor observed ULP-E administer medications to R3. R3's IAPP dated August 6, 2024, included the following area of vulnerability: -resident susceptible to abuse from another individual, including other vulnerable adults R3's IAPP did not include specific interventions for the identified vulnerability listed above as required. On October 9, 2024, at 8:33 a.m. clinical nurse supervisor (CNS)-B reviewed R1 and R3's IAPP and stated the IAPP was missing interventions for identified vulnerabilities for both R1 and R3. The licensee's Individual Abuse Prevention Plan policy dated July 20, 2021, indicated the licensee would develop and implement and individual abuse prevention plan for each vulnerable adult. The plan would 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. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c	0 640		

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0 640	Continued From page 5 The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: The licensee failed to post information and the reporting number for MAARC to report suspected maltreatment of a vulnerable adult under section 626.557.	0 640		

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0 640	Continued From page 6 On October 7, 2024, at 9:30 a.m., the surveyor observed the entry and common areas within the facility and noted there was no posting of the information and reporting number for MAARC, as required. Licensed assisted living director (LALD)-A stated the MAARC information was not posted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the	0 730		

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0 730	Continued From page 7 resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to include the required content in a discharge summary for one of one discharged resident (R4). 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).	0 730		

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0 730	Continued From page 8 The findings include: R4 was admitted to the licensee on May 16, 2024, and discharged on August 19, 2024. R4's discharge summary dated August 19, 2024, lacked the following required content: -a summary of the resident's stay that includes diagnoses, course of illnesses, allergies, treatments and therapies and pertinent lab, radiology, and consultation results; -a final summary of the resident's status from the latest assessment or review under Minnesota Statues, section 144G.70, if applicable, that includes the resident status, including baseline and current mental, behavioral, and functional status; -a reconciliation of all predischarge medications with the resident's post discharge prescribed and over-the-counter medications; and -a post discharge plan that is developed with the resident and, with the resident's consent, the resident's representatives, which will help the resident adjust to a new living environment. The post discharge plan must indicate where the resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any post discharge medical and nonmedical services the resident will need. On October 9, 2024, at 8:40 a.m., clinical nurse supervisor (CNS)-B stated R4's discharge summary did not include all the required content as listed above. The licensee's Contract Termination policy dated August 1, 2021, indicated at the time of discharge, the licensee would provide the resident, and with resident's consent, the resident's representatives and case manager,	0 730		

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0 730	Continued From page 9 with a written discharge summary that included: -a summary of the resident's stay that includes diagnoses, courses of illnesses, allergies, treatments, and therapies, and pertinent lab, radiology, and consultation results -a final summary of the resident's status from the latest assessment or review, if applicable, which includes the resident status, including baseline and current mental, behavioral, and functional status -a reconciliation of all predischarge medications with the residents' post-discharge prescribed and over-the-counter medications, and -a post-discharge care plan that is developed with the resident and, with the resident's consent, the resident's representatives, which will help the resident adjust to a new living environment. The post-discharge care plan will indicate where the resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any post-discharge medical and nonmedical services the resident will need. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of	01500		

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01500	Continued From page 10 vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased	01500		

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01500	Continued From page 11 incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of two employees (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-E was hired on June 27, 2023, to provide direct care and services to the facility's residents. On October 8, 2024, at 9:11 a.m., the surveyor observed ULP-E administer medications to R3. ULP-E's employee record lacked evidence the employee had successfully completed annual training as required, to include the following: - reporting of maltreatment of vulnerable adults under section 626.557;	01500		

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SUITE LIVING SENIOR CARE OF LAKEVILLE L	20949 KEOKUK AVENUE LAKEVILLE, MN 55044

(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
01500	Continued From page 12 - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; and - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures On October 9, 2024, at 9:40 a.m., licensed assisted living director (LALD)-A stated ULP-E had been assigned the above required annual training but had not completed it yet. The licensee's Annual Required Staff Training policy dated July 20, 2021, indicated all staff would complete at least eight hours of annual training for each 12 months of employment to include: -training on reporting of maltreatment of vulnerable adults under section 626.557 -review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident	01620		

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01620	Continued From page 13 reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing nursing assessments not to exceed 14 days from admission for one of three residents (R2), and failed to conduct ongoing nursing assessments not to exceed 90 days for two of three residents (R1 and R3). 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	01620		

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01620	Continued From page 14 situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2 was admitted on May 9, 2024, with diagnoses that included diabetes. R2's service agreement dated May 9, 2024, indicated R2 received services to include grooming, dressing, bathing, toileting, transfers, ambulation, repositioning, safety checks, housekeeping, laundry, meals, medication administration and diabetic management. R2's ongoing nursing assessments were requested. Assessments dated June 3, 2024, and August 1, 2024, were provided. The June 3, 2024, assessment was completed 25 days after the date of admission, thus exceeding 14 calendar days. R1 R1 was admitted on October 25, 2023, with diagnoses that included chronic respiratory failure and diabetes. R1's service agreement dated June 21, 2024, indicated R1 received services to include grooming, dressing, bathing, toileting, transfers, ambulation, repositioning, safety checks, ace wraps/stockings, housekeeping, laundry, meals, medication administration, diabetic management, and oxygen therapy. R1's ongoing nursing assessments were requested. Assessments dated March 21, 2024, July 15, 2024, and September 20, 2024, were provided.	01620		

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01620	Continued From page 15 The July 15, 2024, assessment was completed 116 days after the date of the previous assessment, thus exceeding 90 calendar days. R3 R3 was admitted on January 30, 2024, with diagnoses that included dementia. R3's service agreement dated January 30, 2024, indicated R3 received services to include grooming, dressing, bathing, toileting, transfers, ambulation, repositioning, safety checks, ace wraps/stockings, housekeeping, laundry, meals, and medication administration. R3's ongoing nursing assessments were requested. Assessments dated February 12, 2024, and May 15, 2024, were provided. The May 15, 2024, assessment was completed 93 days after the date of the previous assessment, thus exceeding 90 calendar days. On October 9, 2024, at 8:44 a.m., clinical nurse supervisor (CNS)-B stated R2, R1, and R3's assessments were not completed within the required time frame. The licensee's Initial and On-going Nursing Assessments of Residents policy dated August 1, 2021, indicated an RN would complete comprehensive nursing assessments of resident's physical, mental, and cognitive needs as required up to 14- days after start of services, periodically but no less than every 90-days and with change in resident condition. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01620		

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01620	Continued From page 16 (21) days	01620		
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: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01640		

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01640	Continued From page 17 cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted on October 25, 2023, with diagnoses that included chronic respiratory failure and diabetes. On October 7, 2024, at 11:15 a.m., the surveyor observed R1 with bilateral wrist splints on. R1's service agreement dated June 21, 2024, indicated R1 received services to include grooming, dressing, bathing, toileting, transfers, ambulation, repositioning, safety checks, ace wraps/stockings, housekeeping, laundry, meals, medication administration, diabetic management, and oxygen therapy. R1's service agreement did not include wrist splints. On October 7, 2024, at 11:40 a.m., unlicensed personnel (ULP)-C stated R1 was supposed to put on her own wrist splints, but often requested staff assistance so the staff would put them on or take them off for her. On October 9, 2024, at 8:45 a.m., clinical nurse supervisor (CNS)-B stated R1's service agreement did not include wrist splints because R1 was supposed to be independently managing them. CNS-B further stated since the ULP were assisting R1 with the wrist splints, she would add the service to R1's service agreement. The licensee's Service Plan policy dated July 20, 2021, indicated any revisions or updates to the	01640		

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01640	Continued From page 18 service plan would be entered into the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for all medications the provider managed for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted on October 25, 2023, with diagnoses that included chronic respiratory failure and diabetes.	01820		

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01820	Continued From page 19 On October 7, 2024, at 11:40 a.m., the surveyor observed unlicensed personnel (ULP)-C check R1's blood sugar. R1's service agreement dated June 21, 2024, indicated R1 received assistance with medication and diabetic management. MORPHINE R1's prescriber orders dated June 20, 2024, included the following: -Morphine Sulfate 5 milligrams (mg); give one tablet sublingually every one hour as needed for shortness of breath and or pain R1's medication administration record (MAR) dated October 2024, did not include an order for Morphine Sulfate. On October 9, 2024, at 8:46 a.m., clinical nurse supervisor (CNS)-B stated R1's Morphine was discontinued when she was recently discharged from Hospice. CNS-B further stated she could not locate the discharge order in R1's record. CNS-B then stated she contacted R1's prescriber to request an order to discontinue the Morphine. GLUCOSE R1's prescriber orders dated June 20, 2024, include the following: - glucose oral chewable tablet 4 grams (gm); give one tablet by mouth as needed for hypoglycemia (low blood sugar) R1's glucose order lacked the following: - the frequency in which to administer the glucose tablet - define what blood sugar result was considered a low blood sugar	01820		

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01820	Continued From page 20 On October 9, 2024, at 8:47 p.m., CNS-B stated R1's glucose order did not include frequency for administration. CNS-B further stated the order did not indicate what blood sugar result would be considered low enough to administer the glucose. The licensee's Medication and Treatment Orders policy dated July 20, 2021, indicated an order for medication or treatment must contain the name of the resident, a description of the medication, treatment, or therapy to be provided and the frequency, duration, and other information needed to carry out the order. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable,	01910		

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01910	Continued From page 21 quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one discharged resident (R4). 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 was admitted to the licensee on May 16, 2024, and discharged on August 19, 2024. R4's discharge summary dated August 19, 2024, indicated R4 received assistance with medication management, and R4's medications were "sent to Burnsville". R4's record lacked a medication disposition record at the time of discharge to include the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. On October 9, 2024, at 8:47 a.m., clinical nurse	01910		

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01910	Continued From page 22 supervisor (CNS)-B stated R4 transferred to a sister facility and should have a disposition of medications in R4's record, but it could not be located. The licensee's Medication Disposal policy dated August 1, 2021, indicated upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, date of disposition, and names of staff (including a witness) and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment or therapies were administered as prescribed, or to	01960		

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01960	Continued From page 23 document the reason they were not provided, for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted on October 25, 2023, with diagnoses that included chronic respiratory failure and diabetes. R1's service agreement dated June 21, 2024, indicated R1 received services to include grooming, dressing, bathing, toileting, transfers, ambulation, repositioning, safety checks, ace wraps/stockings, housekeeping, laundry, meals, medication administration, diabetic management, and oxygen therapy. R1's service agreement did not include wrist splints. R1's signed prescriber orders dated June 20, 2024, included: -Velcro Wraps and Compression Stockings: Application and Removal. Bedtime: Must remove, rinse in sink, wring out water really well, and hag dry in bathroom one time a day. Apply compression stockings and Velcro wraps every morning AFTER lymphedema pump treatments are completed and removed per schedule. R1's record lacked prescriber orders for wrist splints.	01960		

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01960	Continued From page 24 On October 7, 2024, at 11:15 a.m., the surveyor observed R1 with bilateral wrist splints on. On October 7, 2024, at 11:40 a.m., unlicensed personnel (ULP)-C stated R1 was supposed to put on her own wrist splints but often requested staff assistance, so staff will put them on or take them off for R1. At 11:44 a.m., the surveyor observed ULP-C apply bilateral compression stockings on R1's lower extremities. ULP-C did not apply R1's lymphedema Velcro wraps to her lower extremities. The surveyor inquired if R1 was supposed to wear lymphedema Velcro wraps and ULP-C stated R1 refused to wear them. R1's medication administration record (MAR) dated October 2024, included: -"Velcro Wraps and Compression Stockings: Application and removal. Bedtime: must remove, rinse in sink, wring out water really well, and hang dry in bathroom one time a day. Apply compression stockings and Velcro wraps every morning AFTER lymphedema pump treatments are completed and remove per schedule". The MAR did not include assistance with wrist splints. In addition, R1's record lacked documentation of R1 refusing to wear lymphedema Velcro wraps. R1's services task sheet dated October 2024, including the following: - "lymphedema wraps requires assistance with putting on and taking off two times per day" The services task sheet did not include assistance with wrist splints. On October 8, 2024, at 12:34 p.m., regional director of nursing (RDON)-F stated the ULP were not documenting when R1 refused her Velcro wraps because the Velcro wraps and	01960		

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SUITE LIVING SENIOR CARE OF LAKEVILLE L	20949 KEOKUK AVENUE LAKEVILLE, MN 55044

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01960	Continued From page 25 compression stockings were listed together and if the ULP documented refused it would indicate R1 refused both the Velcro wraps and compression stockings. RDON-F further stated she separated the Velcro wraps and compression wraps so that the ULPs could document them as individual services instead of a combined service. On October 9, 2024, at 8:50 a.m., clinical nurse supervisor (CNS)-B stated the ULP were not documenting assistance with R1's wrist splints because R1 was supposed to manage them independently. However, since the ULP did assist R1 with her wrist splints there should have been documentation of this service being provided. The licensee's Medication and Treatment Record-Documentation and Refusal policy dated July 20, 2021, indicated the following: -if a medication and or treatment/therapy assistance and/or administration were not completed as prescribed, documentation must include the reason why it was not completed and any follow up procedures that were provided -documentation of medication/treatment/therapy assistance will be completed by the person who performed the task immediately after the assistance is completed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39344	A. BUILDING: _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SENIOR CARE OF LAKEVILLE L	20949 KEOKUK AVENUE LAKEVILLE, MN 55044

(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
01970	Continued From page 26 order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of one resident (R1) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted on October 25, 2023, with diagnoses that included chronic respiratory failure and diabetes. R1's service agreement dated June 21, 2024, indicated R1 received services to include grooming, dressing, bathing, toileting, transfers, ambulation, repositioning, safety checks, ace wraps/stockings, housekeeping, laundry, meals, medication administration, diabetic management, and oxygen therapy. R1's service agreement did not include wrist splints.	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39344	A. BUILDING: _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SENIOR CARE OF LAKEVILLE L	20949 KEOKUK AVENUE LAKEVILLE, MN 55044

(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
01970	Continued From page 27 R1's record lacked prescriber orders for wrist splints. On October 7, 2024, at 11:15 a.m., the surveyor observed R1 with bilateral wrist splints on. On October 7, 2024, at 11:40 a.m., unlicensed personnel (ULP)-C stated R1 was supposed to put on her own wrist splints but often requested staff assistance. Therefore, staff will put them on or take them off for R1. On October 8, 2024, at 8:51 a.m., clinical nurse supervisor (CNS)-B stated R1's record lacked prescriber orders for wrist splints because she was not aware that staff was assisting with the splints. CNS-B further stated she contacted R1's provider and requested an order. The licensee's Medication and Treatment Orders policy dated July 20, 2021, indicated a current, authorized prescriber order for medications or treatments administered by staff would be on file and kept in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *10/07/24*
Time: 12:15:00
Report: 1043241291

Food and Beverage Establishment Inspection Report

Location:
SUITE LIVING SENIOR CARE OF LA
20949 KEOKUK AVENUE
Lakeville, MN55044
Dakota County, 19

Establishment Info:
ID #: 0043709
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/24

Operator:

Phone #:
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.

4-500 Equipment Maintenance and Operation

4-501.114F ***** Priority 1 *****

MN Rule 4626.0805F Provide and maintain a chemical sanitizer generated by a device on site at the food establishment that complies with 7US Code 136 to 136q, 40CFR.152.500 and 156.10, displays the US EPA device manufacturing facility registration number on the device and is operated and maintained according to manufacturer's instructions.

FACILITY USES SINK & SURFACE. NO SUPPLY AVAILABLE FOR DISPENSER. ADVISED STAFF TO PROVIDE AND MAINTAIN. PER STAFF, SUPPLY WAS ORDERED PRIOR TO INSPECTION. COMPLY WITH ABOVE RULE.

Comply By: 10/07/24

3-500C Microbial Control: date marking

3-501.17A ***** Priority 2 *****

MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded.

FACILITY HAS ESTABLISHED DATE MARKING PROCEDURES. SOME FOOD (CUT LETTUCE & TOMATO, SOUP) IN THE COOLER AND FREEZER PREPPED/COOKED FROM THE PAST WEEKEND OBSERVED WITH NO DATE MARKING. ADVISED STAFF TO PROVIDE. COMPLY WITH ABOVE RULE.

Comply By: 10/07/24

Type: Full
Date: *10/07/24*
Time: 12:15:00
Report: 1043241291
SUITE LIVING SENIOR CARE OF LA

Food and Beverage Establishment Inspection Report

4-300 Equipment Numbers and Capacities

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

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

FACILITY USES SINK & SURFACE. CURRENT TEST KIT EXPIRED 01/2024. ADVISED STAFF TO PROVIDE AND MAINTAIN. PER STAFF, REPLACEMENT WAS ORDERED PRIOR TO INSPECTION. COMPLY WITH ABOVE RULE.

Comply By: 10/07/24

3-300B Protection from Contamination: cross-contamination, eggs

3-302.12

MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from orginal packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.

BULK CONTAINERS OF DRY INGREDIENTS (PANKO, FLOUR, SUGAR, ETC) OBSERVED WITH NO DATE MARKING. ADVISED STAFF TO PROVIDE AND MAINTAIN. STAFF CORRECTED ON SITE. COMPLY WITH ABOVE RULE.

Comply By: 10/07/24

4-600 Cleaning Equipment and Utensils

4-602.11E

MN Rule 4626.0845E Clean surfaces contacting food that is not TCS: 1. at any time when contamination may have occurred; 2. at least once every 24 hours for iced tea dispensers and consumer self-service utensils; 3. before restocking consumer self-service equipment and utensils such as condiment dispensers, and display containers; 4. at a frequency specified by the manufacturer or at a frequency necessary to preclude accumulation of soil or mold for ice bins, beverage dispensing nozzles, enclosed components of ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment.

BUILD UP OF BLACK MICROBIAL GROWTH OBSERVED IN THE INTERIOR OF THE KITCHEN ICE MACHINE. ADVISED STAFF TO CLEAN AND MAINTAIN CLEAN. COMPLY WITH ABOVE RULE.

Comply By: 10/07/24

Surface and Equipment Sanitizers

S/S LACTIC ACID: = 704 PPM at Degrees Fahrenheit
Location: SANI SPRAY BOTTLE
Violation Issued: No

HOT WATER: = at 160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: BEANS
Temperature: 153 Degrees Fahrenheit - Location: STEAM WELL
Violation Issued: No

Process/Item: MIXED VEGGIES
Temperature: 144 Degrees Fahrenheit - Location: STEAM WELL
Violation Issued: No

Process/Item: CHICKEN
Temperature: 150 Degrees Fahrenheit - Location: STEAM WELL
Violation Issued: No

Process/Item: RAW EGG BAG
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER 1
Violation Issued: No

Process/Item: CREAM
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER 1
Violation Issued: No

Process/Item: CHEESE
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER 2
Violation Issued: No

Process/Item: COOKED RIBS
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER 2
Violation Issued: No

Process/Item: BUTTER
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER 2
Violation Issued: No

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

Inspection was completed with Sydney Vargo (Housing Director), Allen Mataczynski (Chef) and Kassie Marking as the lead Health Regulation Division Nurse Evaluator completing the site survey.

Discussed highly susceptible populations, date marking, illness policy, sanitizer use, ware washing, temperature control, cleaning, vomit/fecal procedures, test kits, food storage, and food handling procedures.

This facility has a commercial kitchen. Foods cooked in house must be fully cooked (exception for pasteurized eggs) for highly susceptible populations.

Contact Health Regulation Division for plan review approval when kitchen undergoes remodeling.

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

Type: Full
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SUITE LIVING SENIOR CARE OF LA

Food and Beverage Establishment Inspection Report

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 1043241291 of 10/07/24.

Certified Food Protection Manager: Allen Mataczynski

Certification Number: FM117844 Expires: 06/19/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Sydney Vargo
Housing Director

Signed: _____
Blia Lor
Public Health Sanitarian I
651-355-0641
blia.lor@state.mn.us