Electronically Delivered

August 22, 2022

Administrator
Suite Living Of Roseville
197 County Road B2 West
Roseville, MN 55113

RE: Project Number(s) SL33954015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on June 30, 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, no immediate fines are assessed.

**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:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place

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 St. Paul, MN 55164-0970

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 |
|---|---|---|---|
| | 33954 | A. BUILDING: _____ B. WING _____ | 06/30/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SUITE LIVING OF ROSEVILLE | 197 COUNTY ROAD B2 WEST ROSEVILLE, MN 55113 |

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| 0 000 | Initial Comments<br><br>Initial comments<br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br>SL33954015<br><br>On June 28, 2022, though June 30, 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 was trenty-four (24) residents who received assisted living service | 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 License 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 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 surveyors' findings is the Time Period for Correction.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 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<br><br>(13) offer to provide or make available at least the following services to residents:<br><br>(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:<br><br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This had the potential to affect all 24 current residents of the facility.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>Please refer to the additional documentation included in the Food and Beverage Establishment | 0 480 | | |

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| 0 480 | Continued From page 2<br>Inspection Reports, dated June 28, 2022.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 480 | | |
| 0 680 SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(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;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing tenant residents.<br>(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.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to have a written | 0 680 | | |

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| 0 680 | Continued From page 3<br><br>emergency preparedness plan with all the required content and failed to post an emergency preparedness plan prominently. In addition, the licensee failed to provide the minimum frequency of inspection, maintenance, and load test requirements for the emergency power generator as part of the emergency plan to ensure the proper performance of the generator. This had the potential to affect all twenty-four (24) residents receiving services under the assisted living license, staff, and visitors.<br><br>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).<br><br>The findings include:<br><br>1) During the entrance conference on June 28, 2022, at 11:15 a.m., a request was made to view the licensee's emergency preparedness plan.<br><br>The licensee's plan lacked the following required content:<br>-current, all-hazards approach facility assessment<br>-description of the population served by licensee<br>-process for emergency preparedness (EP) cooperation with state and local EP officials/organizations<br>-subsistence needs for staff and residents during an emergency situation<br>-procedure for tracking staff and residents<br>-development of all policies/procedures, based on assessment, and additional policies for:<br>-potential evacuation | 0 680 | | |

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| 0 680 | Continued From page 4<br><br>-sheltering in place<br>-handling medical documents<br>-handling and use of volunteers<br>-arrangement with other facilities (including sister facilities)<br>-development of a communication plan, including primary and alternate means for communication<br>-methods for sharing information<br>-EP training and testing program<br>-EP training program for staff (including documentation of training provided)<br>-annual EP testing requirements.<br><br>2) On June 29, 2022, at approximately 2:00 p.m., survey staff received a monthly log relating to the emergency generator maintenance and inspection from the housing director (HD)-C for review. The documentation review indicated the licensee failed to provide the minimum frequency of inspections, maintenance, and insufficient load test records to meet the requirements for the emergency power generator as outlined under NFPA 110, (referenced under the Code of Federal Regulations, title 42, section 483.73) as part of the facility's emergency plan required under Minnesota Rules, Part 4659.0100, to ensure proper performance of the generator:<br>-No weekly inspections of the generator systems were provided for review.<br>-Monthly load tests were noted on a monthly log, but lacked specific information on required run time such as start and stop time, load under test, date of test, etc .<br>-No records of monthly transfer switch operation tests.<br><br>On June 29, 2022, at 1:30 p.m., the HD- C confirmed the current emergency preparedness plan lacked all required content. HD-C further explained the licensee did not develop a disaster | 0 680 | | |

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| 0 680 | Continued From page 5<br>program to apply specifically to the facility. And at 3:00 p.m., the HD-C acknowledged the findings that the maintenance and inspection records on the emergency generator were not met.<br><br>The licensee's policy Disaster Planning and Emergency Preparedness, dated July 21, 2021, indicated the facility would have in place a general emergency preparedness plan that is in alignment with the facility's requirement to also comply with CMS Appendix Z.<br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 680 | | |
| 0 790 SS=F | 144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment<br><br>(2) install and maintain portable fire extinguishers in accordance with the State Fire Code;<br><br>(3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, record review, and interview, the licensee failed to maintain portable fire extinguishers in accordance with the State Fire Code as required by MN Statute 144G.45 Subd(a)(2). This had the potential to directly | 0 790 | | |

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| 0 790 | Continued From page 6<br>affect all residents and staff.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents).<br><br>The findings include:<br><br>On June 29, 2022, between the hours of 12:10 p.m. and 1:15 p.m., survey staff toured the facility with the director of operations (DO)-F. At approximately 1:50 p.m., the housing director (HD)-C took over the survey and the DO-F left the building. During the tour with the DO-F, survey staff observed the portable fire extinguishers were tagged showing the annual service date of April 2022, but the tags lacked records to show the required monthly visual inspections were performed and recorded for the portable fire extinguishers located throughout the building. The DO-F verified the findings as she commented that she had not been cited on this before. Survey staff explained to the DO-F that the required monthly visual inspection of each extinguisher was necessary to ensure all portable extinguishers are readily available, fully charged, and operable, at their designated location, and had no obvious physical damage or condition to the extinguisher to prevent their operation when needed. If extinguishers were comprised or questionable, the licensee will need to get them to a vendor for servicing such as recharging or maintenance. | 0 790 | | |

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| 0 790 | Continued From page 7<br><br>On June 29, 2022, at approximately 3:00 p.m., the HD-C acknowledged the findings at the exit interview.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 790 | | |
| 0 800 SS=F | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents and staff.<br><br>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 residents).<br><br>The findings include: | 0 800 | | |

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| 0 800 | Continued From page 8<br><br>On June 29, 2022, between the hours of 12:10 p.m. and 1:15 p.m., survey staff toured the facility with the Director of Operations (DO)-F. At approximately 1:50 p.m., the housing director (HD)-C took over the survey and the DO-F left the building. During the tour, staff observed and the DO-F verified the following findings:<br><br>1) The 60-minute fire-rated door to the trash room with overhead door access to the outside failed to self-close to maintain the fire rating of the room.<br><br>2) The door to the sprinkler riser room failed to latch when closed.<br><br>3) Resident room #16 consisted of a strong urine odor and dark staining was observed on the carpet near the sofa chair. The DO-F agreed and explained that the carpet was designed for quick localized replacement when necessary.<br><br>4) Resident room #23 had stained carpet near the bed. Survey staff asked about the cleaning schedule of the resident carpet and the DO-F explained they have the carpet scheduled to be professionally cleaned every six months and on an as-needed basis with their in-house carpet cleaner.<br><br>On June 29, 2022, at approximately 3:00 p.m. the HD-C acknowledged the findings at the exit interview.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Fourteen (14) days | 0 800 | | |

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| 0 810 | Continued From page 9 | 0 810 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on record review, and interview, the licensee failed to provide all required content on | 0 810 | | |

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| 0 810 | Continued From page 10 | 0 810 | | |

the fire safety and evacuation plan, required employee training on the fire safety and evacuation plan, and the minimum number of evacuation drills. This has the potential to directly affect the safety of all residents receiving care, staff, and visitors.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).
The findings include:

On June 29, 2022, at approximately 1:30 p.m., survey staff reviewed the facility's fire safety and evacuation plan, drill, and training documentation. The documentation review indicated the following:

FIRE SAFETY AND EVACUATION PLAN
1)The fire safety and evacuation plan, policy documents 9.06 and 9.07, dated July 20, 2021, lacked procedures for addressing resident movement, evacuation, and relocation that included unique or unusual resident-specific needs during a fire or similar emergency evacuation. Survey staff explained to the HD-C that unique situations that must be addressed in the plan were ambulatory or non-ambulatory residents such as wheelchair-bound, residents with walkers, cognitive deficit residents, and those residents needing additional assistance during a fire or similar emergency.
2) The fire safety and evacuation plan, policy documents 9.06 and 9.07, dated July 20, 2021, lacked fire protection procedures for residents.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 33954 | A. BUILDING: _____ B. WING _____ | 06/30/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUITE LIVING OF ROSEVILLE | 197 COUNTY ROAD B2 WEST ROSEVILLE, MN 55113 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 0 810 | Continued From page 11<br><br>TRAINING<br>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 that the minimum required employee training on the fire safety and evacuation plan had been completed.<br><br>FIRE AND EVACUATION DRILLS<br>The licensee failed to perform the minimum number of fire and evacuation drills as prescribed in their policy document 9.06, dated July 20, 2021, and in accordance with Minnesota Statutes. Record review indicated the following:<br>- Evacuation drills were not included in the recorded fire drills performed by employees. Records showed the listed fire drills performed under "place of resident evacuation" on drill forms dated March 30, 2022, documented "To their rooms" and on May 18, 2022, documented "rooms". Survey staff explained to the HD-C that partial and total evacuation of the building must also be performed to prepare for fire and similar emergencies where total evacuation may be necessary and must be exercised as part of the evacuation drills. Survey staff also explained that the evacuation drills may be performed at the same as fire drills. The HD-C confirmed the finding.<br>-Record review indicated the employee fire drills did not cover all three shifts. The record review of fire drills performed were dated May 18, 2022, at 2:08 p.m., March 30, 2022, at 2:00 p.m., November 10, 2021, at 5:00 p.m., and September 22, 2021, at 2:08 p.m. The HD-C explained that she tried to cover all three shifts where they have the most overlapped number of employees. Survey staff explained that because they have | 0 810 | | |

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| 0 810 | Continued From page 12<br>three work shifts, each shift must perform their fire and evacuation drills consisting of two fire and evacuation drills per shift per year, at minimum once every other month with a minimum total of six drills in a year. The HD-C confirmed the finding.<br><br>On June 29, 2022, at approximately 3:00 p.m., the HD-C acknowledged the findings during the exit interview.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Fourteen (14) days | 0 810 | | |
| 0 970 SS=F | 144.50 Subd. 5 Waivers of liability prohibited<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>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. This had the potential to to affect the twenty-four (24) residents residing in the facility and future residents.<br><br>This practice resulted in a level two violation (a | 0 970 | | |

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|---|---|---|---|---|
| 0 970 | Continued From page 13<br>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).<br><br>The findings include:<br><br>On June 28, 2021, at 11:45 a.m., a copy of the facility's assisted living contract was requested.<br><br>The Suite Living Residency Agreement, section 8, included clauses indicating the provider was not liable to resident In the following incidents:<br><br>-Personal Property of Resident: No Liability of Management. Management had no responsibility to the resident or any third party for any personal property placed in the residency unit or in any other location within the facility or on its grounds by the owner of such person property. Management was not responsible to the resident or any third party for loss of any personal property by theft or any other cause. The resident assumes all risk of harrn or loss to any or resident's personal property.<br><br>- Motor Vehicle Use: No Liability of Management. Resident was solely responsible for personal injury, property damage or other loss as a result of resident's owning, maintaining, operating and/or parking a motor vehicle on or off the premises of the facility.<br><br>-No Liability or Management for Certain Other Losses or Damages. Resident acknowledged familiarity with the residency unit, the premises and services offered by management and was | 0 970 | | |

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| 0 970 | Continued From page 14<br><br>therefore willing to, and assumed all risks associated with occupancy. Resident further acknowledged management was not an insurer of resident's safety. Management was not responsible for resident conduct or omissions of act or speech. Management, its employees. and its agents were not liable to resident or to any other person for any loss or inconvenience of any kind, including personal injuries sustained by resident or any other person, or any loss or damage to property. which was not the direct result of intentional or negligent acts in violation of applicable standards of care.<br>Management was not responsible for the actions of, or for any damage, injury or harm caused by third parties (such as other residents, family members, guests, intruders, or trespassers) who were not Management's control and acting within the scope of their authority.<br><br>By occupying the residency unit, the resident acknowledged the resident inspected it (the unit) and found it to be thoroughly cleaned and accepted it in its then present condition without any<br>obligation on the part of management to make any further cleaning, alterations.<br>improvements or repairs except as would be acknowledged in a separate document signed by management.<br><br>On June 30, 2022, at 10:30 a.m., housing director (HD)-C confirmed the assisted living contract required residents to waive the facility's liability for health, safety, or personal property. HD-C confirmed the same assisted living contract was used for all residents residing in the facility.<br><br>The Assisted Living License Resource Manual | 0 970 | | |

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| 0 970 | Continued From page 15<br>policy, Signing an Assisted Living Contract, revised August 1, 2021, stated when a prospective resident decided to move into Suite Living a contract was to be signed and received by the facility. The policy to not address liabillity.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) daysBased on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for resident health, safety, or personal property. This had the potential to affect all residents. | 0 970 | | |
| 01890 SS=D | 144G.71 Subd. 20 Prescription drugs<br><br>A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure time sensitive medications were labeled with a readable date when opened and discarded when expired for one of two residents (R2) with medication storage reviewed.<br><br>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 | 01890 | | |

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|---|---|---|---|---|
| 01890 | Continued From page 16 | 01890 | | |

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).

On June 29, 2022, at 8:35 a.m., the licensee's medication administration and storage review was observed. An unlicensed personnel (ULP)-D prepared medication for a resident (R)-2 which included Lantus solution 100 units/ML (milliliter) Solostar pen (a multiple dose pen shaped injector device for insulin). Although the label on R2's Lantus pen had a date written with red marker, ULP-D verified it was illegible due to "smearing and rubbing off." ULP-D proceeded to complete medication preparation for administration for R2. ULP-D approached R2 and stated she was going to administer R2's insulin. The surveyor questioned ULP-D regarding the efficacy of the medication (Lantus) without knowledge of an open or expiration date. ULP-D stated she was going to speak with her supervisor.

On June 29, 2022, at 8:54 a.m., ULP-D returned with an unopened Lantus Solostar pen for R2. ULP-D dated the insulin, using a permanent ink pen, with an open and expiration date. ULP-D then administered the insulin as per active order, dated November 13, 2020.

On June 30, 2022, at 9:50 a.m., the registered nurse (RN)-B stated
staff should always ensure labels are marked with an opened and expiration date that was legible, using permanent ink. RN-B also stated if a medication cannot be verified when opened or expired, a new medication should be obtained.

The Licensee's Medication Storage Policy, dated

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| 01890 | Continued From page 17<br>July 2021, stated medications would be stored consistent with manufacturer's recommendations.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven | 01890 | | |
| 02110 SS=F | 144G.82 Subd. 3 Policies<br><br>(a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the:<br>(1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented;<br>(2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed;<br>(3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes;<br>(4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications;<br>(5) staff training specific to dementia care;<br>(6) description of life enrichment programs and how activities are implemented;<br>(7) description of family support programs and efforts to keep the family engaged;<br>(8) limiting the use of public address and intercom systems for emergencies and evacuation drills only;<br>(9) transportation coordination and assistance to | 02110 | | |

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| 02110 | Continued From page 18<br>and from outside medical appointments; and<br>(10) safekeeping of residents' possessions.<br>(b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, licensee failed to ensure policies and procedures required in the licensing of assisted living facilities with dementia care were provided to each resident and/or the residents legal/designated representative at the time of move-in. This had the potential to affect all residents with dementia care, staff, and visitors.<br><br>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).<br><br>The findings include:<br><br>The licensee lacked evidence the required policies and procedures related to dementia care were provided to each resident and/or the resident's legal and designated representative.<br><br>The licensee held an assisted living with dementia care license through October 31, 2023 and was licensed for a bed capacity of 24 residents. | 02110 | | |

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| 02110 | Continued From page 19<br><br>On June 30, 2022, at 12:00 p.m., registered nurse (RN)-B and the Housing Director (HD)-C confirmed the inclusive list of dementia care policies and procedures had not been provided to each resident and/or representative.<br><br>The licensee's Assisted Living License Resource Manual Policy Assisted Living with Dementia Care Additional Required Policies, revised 0/20/21, indicated the required written policies and procedures for a facility with an Assisted Living with Dementia Care license, must be provided to residents and the residents' legal and designated representatives at the time of move-in.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days<br><br>On June 30, 2022, at 12:00 p.m., registered nurse (RN)-B and the Housing Director (HD)-C confirmed the inclusive list of dementia care policies and procedures had not been provided to each resident and/or representative.<br><br>The licensee's Assisted Living License Resource Manual Policy Assisted Living with Dementia Care Additional Required Policies, revised 0/20/21, indicated the required written policies and procedures for a facility with an Assisted Living with Dementia Care license, must be provided to residents and the residents' legal and designated representatives at the time of move-in.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One | 02110 | | |

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| 02110 | Continued From page 20<br>(21) days | 02110 | | |

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

Type: Full
Date: *06/28/22*
Time: 11:57:45
Report: 1021221187

# Food and Beverage Establishment Inspection Report



**Location:**
Suite Living Of Roseville
197 County Road B2 West
Roseville, MN55113
Ramsey County, 62

**Establishment Info:**
ID #: 0039398
Risk:
Announced Inspection: Yes

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 6514240075
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.

**2-500 Responding to contamination events**

2-501.11 ** Priority 2 **

MN Rule 4626.0123 Provide employees with procedures to follow for cleanup of vomit or fecal matter in the establishment. The procedures must minimize the spread of contamination to food and surfaces within the facility, and minimize the exposure of employees and consumers to contamination.

NO PROCEDURES ON-SITE TO FOLLOW FOR A CLEANUP OF VOMITING/FECAL ACCIDENTS IN THE KITCHEN. INFORMATION ON HOW TO CLEAN UP A VOMITING/FECAL ACCIDENT SENT WITH REPORT. KITCHEN MANAGER WILL PROVIDE TRAINING AND PROCEDURES FOR ANY NEW KITCHEN STAFF.

*Comply By: 06/28/22*

**4-600 Cleaning Equipment and Utensils**

4-601.11A ** Priority 2 **

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

CAN OPENER BLADE CONTAINS ACCUMULATION OF DRIED FOOD DEBRIS. CLEAN AND SANITIZE CAN OPENER AFTER EACH USE. MANAGER SENT CAN OPENER THROUGH THE DISH MACHINE DURING INSPECTION. CORRECTED ON-SITE.

*Comply By: 06/28/22*

**4-600 Cleaning Equipment and Utensils**

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

VENTILATION HOOD FILTERS CONTAIN ACCUMULATION OF GREASE AND DUST. INSIDE PART OF MICROWAVE CONTAINS SPLASHING OF DRIED FOOD DEBRIS. CLEAN IN-

BETWEEN KITCHEN EQUIPMENT UNDER THE VENTILATION HOOD.
*Comply By: 07/01/22*

**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.

INTERIOR TOP PART OF THE KITCHEN ICE MACHINE CONTAINS ACCUMULATION OF HARD WATER RESIDUE. CLEAN AND SANITIZE ICE MACHINE.

*Comply By: 07/01/22*

**Surface and Equipment Sanitizers**

Sink & Surface Sanitizer: = 700PPM at Degrees Fahrenheit
Location: THREE COMPARTMENT SINK DISPENSER
Violation Issued: No

Sink & Surface Sanitizer: = 700PPM at Degrees Fahrenheit
Location: SANI BUCKET
Violation Issued: No

Final Utensil Surface Temp: = at 165 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

**Food and Equipment Temperatures**

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: CUT FRUIT (CUT MELON) - COOLER #1
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: SLICED HAM - COOLER #1
Violation Issued: No

Process/Item: Cold Holding
Temperature: 48 Degrees Fahrenheit - Location: MILK - COOLER #1 COOLING FROM AMBIENT FOR 1.5 HOURS
Violation Issued: No

Process/Item: Thawing
Temperature: 33 Degrees Fahrenheit - Location: RAW GROUND BEEF - NORPOLE UPRIGHT COOLER

Violation Issued: No

Type: Full
Date: *06/28/22*
Time: 11:57:45
Report: 1021221187
Suite Living Of Roseville

# Food and Beverage Establishment Inspection Report

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

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH KITCHEN MANAGER, RAY BRAUN, AND HEALTH REGULATION DIVISION LEAD NURSE EVALUATOR, MARY BRUESS.

**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 1021221187 of 06/28/22.

Certified Food Protection Manager: RAY BRAUN

Certification Number: FM107463 Expires: 08/23/24

**Inspection report reviewed with person in charge and emailed.**

Signed: _____
RAY BRAUN
KITCHEN MANAGER

Signed: _____
Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us