Electronically Delivered

March 28, 2025

Licensee
Suite Living of Ramsey
7007 139th Lane Northwest
Ramsey, MN 55303

RE: Project Number(s) SL36601016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 26, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

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

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,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 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
	36601	A. BUILDING: _____ B. WING _____	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING OF RAMSEY	7007 139TH LANE NW RAMSEY, MN 55303

(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: SL36601016 On February 24, 2025, through February 26, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 29 resident(s); all receiving services under the Assisted Living Facility with Dementia Care license.	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. 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 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food	0 480		

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0 480	Continued From page 1 must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean	0 480		

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0 480	Continued From page 2 and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 24, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		

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0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all visitors, employees, and residents. 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	0 680		

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0 680	Continued From page 4 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 the residents). The findings include: The licensee's EPP dated October 1, 2022, included a signature from regional director of operations (RDO)-E dated October 4, 2022, indicating the creation and initial review and had not been signed off as having been reviewed since that date. On February 25, 2025, at 11:00 a.m., regional director of operations (RDO)-E stated she had personally reviewed and updated the EPP, but just had not documented it. The licensee's Emergency Plan Organizational Approval and Review and Distribution Plan policy indicated this document is [the facility] emergency preparedness plan and states our understanding of how we anticipate, manage, and conduct actions under emergency conditions. It will be reviewed, along with supporting memorandums of understanding, and updated on an annual basis, and as necessary. This plan has been reviewed by our organization's leadership. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		

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0 775	Continued From page 5	0 775		
0 775 SS=E	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On February 25, 2025, at 12:20 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-A and regional director of operations (RDO)-E. During the facility tour, the surveyor observed the following: Controlled Egress Door Locking System - During the tour, the surveyor observed electromagnetic locks were installed on the emergency exit doors. Keypads were installed at these doors that required entry of a code into the keypad to unlock. During an interview on February 25, 2025, at 1:30 p.m., RDO-E stated the controlled locking system for the main	0 775		

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0 775	Continued From page 6 entrance could also be unlocked using a green button installed in the front office. RDO-E stated this button did not unlock any of the other emergency exit doors with electromagnetic locks. During an interview on February 25, 2025, at 2:45 p.m., LALD-A and RDO-E verified the above listed observations. The entire egress control locking system shall have the capability of being unlocked by a signal or switch from the fire command center, a nursing station, or other approved location. The signal or switch shall directly break power to the lock. Egress control locking systems must comply with Minnesota State Fire Code Rules, Chapter 7511 for the entire locking system. - On February 25, 2025, LALD-A and RDO-E provided emergency plan procedures. Record review indicated the emergency plan did not include procedures to operate and unlock the controlled egress door locking system. During an interview on February 25, 2025, at 2:45 p.m., LALD-A and RDO-E verified this information was not included in the plan. Fire Door Maintenance The labeled fire door was propped open with a wedge for the beauty salon. The room was unoccupied during the tour. Devices used to hold open fire doors must not prohibit the required operation and closing feature of the door. During the tour interview, LALD-A verified the above listed fire door observation. Extension Cord Use An extension cord was used to supply power in resident room 8, creating a fire hazard. During the tour interview, LALD-A verified the above listed extension cord observation.	0 775		

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0 775	Continued From page 7 TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810		

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0 810	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to develop the fire safety and evacuation plan with required content and provide required drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 25, 2025, licensed assisted living director (LALD)-A and regional director of operations (RDO)-E provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee FSEP floor plan in the emergency preparedness manual binder failed to identify the location and number of resident rooms and the emergency exits for the facility. The FSEP floor plan posted at the front entrance did not identify the location of the emergency exits for the facility. On February 25, 2025, at 12:20 p.m., the surveyor toured the facility with LALD-A and RDO-E. During the tour, the surveyor observed the following:	0 810		

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0 810	Continued From page 9 Resident rooms were identified by numbers posted at the doors. Record review of the available documentation indicated the licensee failed to identify the location and number of resident rooms on the FSEP floor plan in the emergency preparedness manual binder. Resident sleeping room numbers are required to be included on the FSEP floor plans and used with the numbers installed on the resident sleeping room doors to provide efficient communication for exiting in the event of a fire or similar emergency. Illuminated exit signs were installed at the emergency exit doors. The FSEP floor plan posted at the front entrance and in the emergency preparedness manual binder did not label the emergency exits for the facility. Exit labels are required to be included on the FSEP floor plans in order to direct occupants to the exits in the event of an emergency. Record review indicated the licensee FSEP was not developed and maintained for the facility location. The FSEP included a fire policy dated July 20, 2021, that was a template from a third-party provider. The FSEP fire policy failed to provide specific employee actions and resident protection procedures to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The FSEP must be developed and maintained with procedures specific to the facility and the building occupants. During an interview, on February 25, 2025, at 2:45 p.m., LALD-A and RDO-E verified the FSEP required revision. RDO-E stated the licensee had already started working on revising the FSEP based on survey feedback received at other facility locations.	0 810		

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0 810	Continued From page 10 DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift evident by a review of fire drill logs lacking the required frequency. Seven fire drills were recorded between January 2024 and January 2025. Fire drills had not been conducted during the morning shift. During an interview, on February 25, 2025, at 2:45 p.m., LALD-A and RDO-E stated some of the fire drills had been completed by combining employee shifts and verified fire drills had not been conducted during the morning shift. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.	01290		

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01290	Continued From page 11 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was affiliated to the current health facility identification (HFID) number for three of three employees on the facility provided employee roster unlicensed personnel (ULP) F, ULP-G, and ULP-H. 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 the residents). The findings include: On February 24, 2025, at 12:50 p.m., the surveyor reviewed the facility's NetStudy 2.0 roster (background study) and compared it to the facility's staff roster and discovered three employees were not affiliated with the licensee's HFID #36601. On February 25, 2025, at 11:15 a.m., licensed assisted living director (LALD)-A stated the staff came from a sister facility and she did not know they needed to be affiliated to both HFIDs and it has already been corrected. The licensee's Background Studies policy dated August 1, 2021, indicated [the facility] will conduct a Minnesota Department of Human Services background study on all employees and volunteers and contractors at [the facility].	01290		

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01290	Continued From page 12 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
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 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 (R2). This practice resulted in a level two violation (a	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36601	A. BUILDING: _____ B. WING _____	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING OF RAMSEY	7007 139TH LANE NW RAMSEY, MN 55303

(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
01640	Continued From page 13 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's service plan lacked revision to reflect the current services R2 was receiving. R2's Service Plan dated June 13, 2024 included assistance with medication administration, dressing and grooming, toileting, bathing, repositioning, transfers, and ambulation. R2's hospital return assessment dated January 16, 2025, indicated R1 required assistance with the c-pap (continuous positive airway pressure) machine daily and assistance with compression stockings twice daily. R2's progress notes dated February 5, 2025, indicated a new order for oxygen at two liters per minute continuous via nasal cannula. R2's treatment administration record for February 2025, indicated staff are assisting with R2's c-pap and compression stockings. On February 26, 2025, at 10:35 a.m., the surveyor observed in R2's apartment compression stockings, a c-pap machine, and R2 was using an oxygen concentrator via nasal cannula. R2 stated staff help her with her oxygen, c-pap machine, and applying and removing her compression stockings.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36601	A. BUILDING: _____ B. WING _____	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING OF RAMSEY	7007 139TH LANE NW RAMSEY, MN 55303

(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
01640	Continued From page 14 On February 26, 2025, at 11:35 a.m., clinical nurse supervisor (CNS)-B stated they omitted assistance with compression stockings in the service plan/agreement, it should have been in the dressing section. CNS-B stated the oxygen service is a recent change and had not yet been added and further stated the c-pap service had not been restarted yet, but the treatment administration record show that staff have been completing this task. CNS-B stated the service plan/agreement should match the assessment and the treatment administration record. The licensee's Service Plan policy dated July 20, 2021, indicated all residents receiving assisted living services will have a service plan in place. Service plans are based on the outcomes of initial and subsequent assessments, reassessments, monitoring, and individual reviews of the resident's needs and preferences. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by:	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36601	A. BUILDING: _____ B. WING _____	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING OF RAMSEY	7007 139TH LANE NW RAMSEY, MN 55303

(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
01890	Continued From page 15 Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications included the opened or expiration date. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On February 25, 2025, at 11:30 a.m., the surveyor observed unlicensed personnel (ULP)-C administer insulin for R1. R1's Lantus and Humalog insulin pens were not labeled with an open or expiration date. Manufacturer's instructions for Lantus and Humalog indicate injection pens should be used within 28 days after opening. On February 25, 2025, at 11:35 a.m., ULP-C stated they were trained to mark insulin pens with the date they were opened and was not sure why it was not done. On February 25, 2025, at 11:55 a.m. clinical nurse supervisor (CNS)-B stated ULP's are trained and expected to use a sticker and write their initials, date opened, and expiration date on insulin pens, eye drops, and some nasal sprays and powders. The licensee's Insulin Pen policy dated August 1,	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36601	A. BUILDING: _____ B. WING _____	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING OF RAMSEY	7007 139TH LANE NW RAMSEY, MN 55303

(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
01890	Continued From page 16 2021, indicated only properly trained staff of [the facility] may provide medication assistance or administration. ULP must be trained, and competency tested by a RN, with documentation on file. Insulin medications must be administered according to the prescriber's orders. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a safety risk assessment or hazard vulnerability assessment of the physical environment on and around the property with mitigation factors to protect the dementia care residents from harm. This deficient practice had the ability to affect all dementia care residents.	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36601	A. BUILDING: _____ B. WING _____	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING OF RAMSEY	7007 139TH LANE NW RAMSEY, MN 55303

(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
02040	Continued From page 17 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). Findings include: On February 25, 2025, licensed assisted living director (LALD)-A and regional director of operations (RDO)-E provided an undated hazard vulnerability assessment that included a mitigation plan for the top 10 hazards identified. This mitigation plan was not specific to the protection of the dementia care residents from the physical environment hazards identified in the assessment. During an interview on February 25, 2025, at 2:45 p.m., LALD-A and RDO-E verified the mitigation plan required revision. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul
6512014500

Type: Full
Date: *02/24/25*
Time: 11:35:20
Report: 1029251056

Food and Beverage Establishment Inspection Report

Location:

Suite Living Of Ramsey
7007 139th Lane Nw
Ramsey, MN55303
Anoka County, 02

Establishment Info:

ID #: 0038379
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 7634027090
ID #:

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

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

3-501.16A1 ***** Priority 1 *****

MN Rule 4626.0395A1 Maintain all hot, TCS foods at 135 degrees F (57 degrees C) or above. Roasts may be held at 130 degrees F (54 degrees C) or above if cooked or reheated in accordance with the specified time and temperature requirements in 4626.0340B.

HOT HELD CHX WINGS STACKED ABOVE INSERT LINE IN STEAM WELL MEASURED IN DANGER ZONE. REP INSTRUCTED TO MAINTAIN TCS HOT HELD ITEMS AT 135F OR ABOVE. ITEMS COME OUT OF OVEN ~11:30 AND ARE SERVED OR DISCARDED W/IN ~90 MIN.

Comply By: 02/24/25

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.

TURKEY POT PIE FILLING MADE ON FRIDAY (2/21) NOT DATE MARKED REP INSTRUCTED TO DATE MARK REQUIRED ITEMS AND TO DISCARD IF NOT USED BY THE END OF THE 7TH DAY. LISTERIA DISCUSSED.

Comply By: 02/24/25

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

PHOTOCOPY OF CFPM CERTIFICATE POSTED. REP INSTRUCTED TO HAVE ORIGINAL OR DUPLICATE POSTED.

Comply By: 02/25/25

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.

MOLD AND BUILDUP IN BACK AREAS OF OF ICE MACHINE. REP INSTRUCTED TO HAVE ICE MACHINE CLEANED MORE THOROUGHLY TO ENSURE ALL MOLD AND BUILDUP ARE REMOVED.

Comply By: 02/24/25

Surface and Equipment Sanitizers

HOT WATER: = at 164 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

LACTIC ACID: = 1875PPM at Degrees Fahrenheit
Location: SANIBUCKET
Violation Issued: No

Food and Equipment Temperatures

Process/Item: COLD HOLD/PORK TENDERLOIN
Temperature: 39 Degrees Fahrenheit - Location: 2-DOOR UPRIGHT
Violation Issued: No

Process/Item: COLD HOLD/COLESLAW
Temperature: 40 Degrees Fahrenheit - Location: 2-DOOR UPRIGHT
Violation Issued: No

Process/Item: COLD HOLD/MILK
Temperature: 39 Degrees Fahrenheit - Location: 2-DOOR UPRIGHT 2
Violation Issued: No

Process/Item: COLD HOLD/POT PIE FILLING
Temperature: 36 Degrees Fahrenheit - Location: 2-DOOR UPRIGHT 2
Violation Issued: No

Process/Item: HOT HOLD/CHX WING
Temperature: 102 Degrees Fahrenheit - Location: STEAM WELL - STACKED ABOVE INSERT LINE
Violation Issued: Yes

Process/Item: HOT HOLD/CHX WING
Temperature: 141 Degrees Fahrenheit - Location: STEAM WELL - UNDER THE INSERT LINE
Violation Issued: No

Type: Full
Date: *02/24/25*
Time: 11:35:20
Report: 1029251056
Suite Living Of Ramsey

Food and Beverage Establishment Inspection Report

Process/Item: HOT HOLD/VEGGIE MEDLEY
Temperature: 200 Degrees Fahrenheit - Location: STEAM WELL
Violation Issued: No

Process/Item: HOT HOLD/MAC & CHEESE
Temperature: 177 Degrees Fahrenheit - Location: STEAM WELL
Violation Issued: No

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

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 1029251056 of 02/24/25.

Certified Food Protection Manager: CIPRE-AUNNI JAVON STEWART

Certification Number: 53791 Expires: 09/05/27

Inspection report reviewed with person in charge and emailed.

Signed: _____

CIPRE STEWART
KITCHEN MANAGER

Signed: Trevor McCliment

Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Report #: 1029251056

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul

No. of RF/PHI Categories Out	4
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 02/24/25
Time In 11:35:20
Time Out

Suite Living Of Ramsey	Address: 7007 139th Lane Nw	City/State: Ramsey, MN	Zip Code: 55303	Telephone: 7634027090
License/Permit #: 0038379	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls: _____

Person in Charge (Signature) **Date:** 02/24/25

Inspector (Signature) *Trevor McCliment*