Electronically Delivered

August 4, 2025

Licensee
Suite Living Senior Care of Burnsville LLC
1880 134th Street East
Burnsville, MN 55337

RE: Project Number(s) SL38412016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 4, 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.

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

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

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

§ 144G.20;
Level 5: a fine of $5,000 per violation, in addtion to any enforcement mechanism authorized in § 144G.20.

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

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38412	A. BUILDING: _____ B. WING _____	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SENIOR CARE OF BURNSVILLE	1880 134TH STREET EAST BURNSVILLE, MN 55337

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ***ATTENTION*** ASSISTED LIVING PROVIDER 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: SL38412016-0 On June 2, 2025, through Jue 4, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 30 residents; 30 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

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0 510	Continued From page 1 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to glove use and handwashing during medication administration by one of one employee (unlicensed personnel (ULP)-G). This had the potential to affect all 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 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 3, 2025, at 7:23 a.m., the surveyor observed ULP-G log into the computer to review R1's medication orders. ULP-G put on gloves and	0 510		

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0 510	Continued From page 2 removed R1's medication cards from the medication cart. ULP-G prepared R1's medications and placed them into a medication cup. ULP-G gathered R1's diabetic supplies and R1's medications and brought them to R1's room. ULP-G administered R1's medications by removing them one at a time with his gloved hand and placing them in R1's mouth. ULP-G then started to prepare to check R1's blood sugar. ULP-G stated he forgot the lancet (instrument used to puncture the skin to obtain a blood sample) and left R1's room to get a lancet from the medication cart. ULP-G returned and checked R1's blood sugar. ULP-G returned to the medication cart, removed his gloves and proceeded to document the medication administration on the computer. ULP-G wore the same pair of gloves while performing the above tasks and did not perform hand hygiene after gloves were removed. On June 3, 2025, at 7:45 a.m., ULP-G stated he should have removed his gloves between tasks and used hand sanitizer. On June 4, 2025, at 9:44 a.m., regional director of nursing (RDON)-E stated she expected the ULP to perform hand hygiene prior to applying gloves and again after gloves were removed. RDON-E further stated the ULP should have changed gloves between performing different tasks. The licensee's Hand Washing policy dated July 20, 2021, indicated handwashing would be performed by all employees, as necessary, between tasks and procedures, and after bathroom use, to prevent cross-contamination. No other information was provided.	0 510		

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0 510	Continued From page 3 TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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 4 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide the required training and 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: June 4, 2025, from 2:30 p.m. to 4:30 p.m., with licensed assisted living director (LALD)-A and maintenance manager (MM)-J; provided documents on the FSEP, fire safety and evacuation training, and evacuation drills for the facility. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD-A stated staff uses a third-party website to conduct fire training along with staff meetings. LALD-A had only been in the position for less than a year and could only	0 810		

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0 810	Continued From page 5 provide one staff training in March 2024. No other training documentation was provided. On June 4, 2025, at 3:30 p.m., LALD-A stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. DRILLS The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Provided documented drills were only conducted on 1st and 2nd shifts, none for overnight shift. On June 4, 2025, at 3:30 p.m., LALD-A stated there were no additional documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01620 SS=D	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 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	01620		

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01620	Continued From page 6 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 90 days 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 November 3, 2022, with diagnoses that included diabetes and hemiplegia (muscle weakness or partial paralysis of one side of the body). R1's service agreement dated October 9, 2024, indicated R1 received services to include dressing, grooming, oral care, toileting, catheter	01620		

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01620	Continued From page 7 care, bathing, transfers, repositioning, safety checks, compression stockings, diabetic management and medication administration. R1's ongoing nursing assessments dated December 2, 2024, March 3, 2025, and June 3, 2025, were reviewed. The March 3, 2025, was completed 91 days after the date of the previous assessment, thus exceeding 90 calendar days. The June 3, 2025, assessment was completed 92 days after the date of the previous assessment, thus exceeding 90 calendar days. On June 4, 2025, at 9:15 a.m., regional director of nursing (RDON)-E stated R1's assessments were not completed within the required time frame. RDON-E stated the licensee was having challenges with their electronic health record system related to scheduling resident assessments accurately. The licensee's Assessments, Reviews and Monitoring policy dated August 1, 2022, indicated resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640		

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01640	Continued From page 8 (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 signed and revised to reflect the current services provided for three of three residents (R1, R2 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 situation has occurred repeatedly; but is not	01640		

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01640	Continued From page 9 found to be pervasive). The findings include: R1 R1 was admitted on November 3, 2022, with diagnoses that included diabetes and hemiplegia (muscle weakness or partial paralysis of one side of the body). On June 3, 2025, at 7:11 a.m., the surveyor observed unlicensed personnel (ULP)-G and ULP-H assist R1 with getting dressed which included removing R1's left wrist brace and applying compression stockings to R1's lower extremities. R1's service agreement dated October 9, 2024, indicated R1 received services to include dressing, grooming, oral care, toileting, catheter care, bathing, transfers, repositioning, safety checks, compression stockings, diabetic management and medication administration. R1's service agreement did not include range of motion (ROM) exercises or left-hand brace. R1's Medication Administration Record (MAR) dated June 2025, included: -Please assist resident to do range of motion exercised per PT/OT (physical therapy/occupational therapy) two times a day for ROM exercises, arms and legs. R2 R2 was admitted on March 6, 2025, with diagnoses that included hemiplegia. On June 3, 2025, at 9:03 a.m., the surveyor observed ULP-C and ULP-I assist R2 with getting dressed which included applying compression	01640		

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01640	Continued From page 10 stockings to R2's lower extremities and putting R2's right arm in a sling. R2's service agreement dated March 6, 2025, indicated R2 received services to include dressing, grooming, oral care, toileting, bathing, transfers, repositioning, safety checks, wrist brace application/removal, heel protector application/removal, and medication administration. R2's service agreement did not include compression stockings or right arm sling. R3 R3 was admitted on March 29, 2023, with diagnoses that included dementia and diabetes. On June 3, 2025, at 9:30 a.m., the surveyor observed R3 sitting at the dining room table and was wearing bilateral compression stockings. ULP-D stated the staff applied the compression stockings every morning. R3's service agreement dated September 27, 2024, indicated R3 received services to include dressing, grooming, oral care, toileting, bathing, transfers, repositioning, safety checks, and medication administration. R3's service agreement did not include compression stockings. R3's service agreement was not signed by R1 or R1's representative. On June 4, 2025, at 9:17 a.m., regional director of nursing (RDON)-E reviewed R1, R2, and R3's service agreements and stated the service plans did not accurately reflect the services being provided. RDON-E stated R3's service agreement was sent to R3's representative to be electronically signed; however, it had not been signed yet.	01640		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 11 The licensee's Service Plan policy dated August 1, 2022, indicated the service plan and any revisions shall include a signature or other authentication by [licensee] and by the resident, or resident's representative, documenting agreement on the services provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01750 SS=E	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse documented resident-specific instructions for three of three residents (R1, R2, and R3) whose medication administration was delegated to unlicensed personnel (ULP). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38412	A. BUILDING: _____ B. WING _____	06/04/2025

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01750	Continued From page 12 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 was admitted on November 3, 2022, with diagnoses that included diabetes and hemiplegia (muscle weakness or partial paralysis of one side of the body). On June 3, 2025, at 7:23 a.m., the surveyor observed ULP-G administer medications to R1. R1's service agreement dated October 9, 2024, indicated R1 received services to include medication administration. R1's Medication Administration Record (MAR) dated June 2025, included: -polyethylene glycol powder 17 grams (g); Give 17 g by mouth every 12 hours as needed for constipation, prescriber order dated December 2, 2024. -Fleet Enema Rectal Enema; insert one applicatorful rectally as needed for constipation daily, prescriber order dated December 2, 2024. The licensee failed to have resident-specific instructions regarding which medications listed above to give in which order for constipation. On June 4, 2025, at 9:19 a.m., regional director of nursing (RDON)-E stated R1's record did not	01750		

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01750	Continued From page 13 have specific-resident directions on when to give polyethylene glycol powder versus fleet enema to R1 for constipation. R2 R2 was admitted on March 6, 2025, with diagnoses that included hemiplegia. On June 2, 2025, at 10:05 a.m., the surveyor observed ULP-D administer medications to R2. R2's service agreement dated March 6, 2025, indicated R2 received services to include medication administration. R2's MAR dated June 2025, included: -guaifenesin oral liquid 100 milligrams (mg)/5 milliliters (ml); give 10 ml by mouth every four hours as needed for cough relief/congestion. Not to exceed six doses/day, order dated April 14, 2025. -guaifenesin solution 200 mg/10 ml; give 10 ml by mouth every four hours as needed for cough up to six doses in 24 hours, order dated February 20, 2025. On June 4, 2025, at 9:20 a.m., RDON-E stated R2's record should only have one order for guaifenesin. RDON-E stated the licensee recently update their standing house orders and the February 20, 2025, order should have been discontinued. R3 R3 was admitted on March 29, 2023, with diagnoses that included dementia and diabetes. On June 3, 2025, at 9:30 a.m., the surveyor	01750		

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01750	Continued From page 14 observed ULP-D administer medications to R3. R3's unsigned, service agreement dated September 27, 2024, indicated R3 received services to include medication administration. R3's signed prescriber orders included: -loperamide 2 milligrams (mg); give two tablets by mouth every 24 hours as needed. Give one tablet by mouth every 12 hours as needed for diarrhea after you have given two tablets PRN (as needed), order dated October 21, 2024. -loperamide 2 mg; give one tablet by mouth three times a day as needed for diarrhea, order dated April 14, 2025. The licensee failed to have resident-specific instructions regarding which loperamide order to use in which order. On June 4, 2025, at 9:25 a.m., RDON-E stated R3's record did not include resident-specific directions for the ULP on which order of loperamide to use in which order. RDON-E stated R3 was admitted to the licensee with a loperamide order, and then the licensee obtained standing house orders for R3 upon admission, which also included an order for loperamide resulting in the two separate orders for loperamide. The licensee's Medication and Treatment - Administration and Delegation policy dated July 2021, indicated prior to ULP providing delegated medication administration and/or treatments/therapy, the following must occur: 1. A RN must conduct a face-to face resident assessment to determine what medication management or treatment/therapy services will be provided and how those services will be	01750		

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01750	Continued From page 15 provided. 2. [Licensee] will prepare and include in the service plan a written statement of the medication management or treatment/therapy services that will be provided to the resident. 3. The medications have current prescriber's orders on file. 4. A RN must specific, in writing, specific instructions for each resident and document those instructions in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01940 SS=E	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy	01940		

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01940	Continued From page 16 services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for three of three residents (R1, R2 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 situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 was admitted on November 3, 2022, with diagnoses that included diabetes and hemiplegia (muscle weakness or partial paralysis of one side of the body). On June 3, 2025, at 7:11 a.m., the surveyor observed unlicensed personnel (ULP)-G and	01940		

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01940	Continued From page 17 ULP-H assist R1 with getting dressed which included removing R1's left wrist brace and applying compression stockings to R1's lower extremities. R1's service agreement dated October 9, 2024, indicated R1 received services to include compression stockings and diabetic management. R1's service agreement did not include range of motion (ROM) exercises or a left-hand brace. R1's signed prescriber orders included: -Check blood sugar QID (four times daily) for diabetes, order dated December 24, 2024. -Apply compression stockings in the morning and remove per scheduled, order dated October 21, 2024. -Please assist resident to do range of motion exercises per PT/OT (physical therapy/occupational therapy) two times a day for ROM exercises. Arms and legs, order dated October 21, 2024 R1's record lacked prescriber orders for a left hand brace. R1's Medication Administration Record (MAR) dated June 2025, included: -Apply compression stockings in the morning and remove per schedule. -Please assist resident to do range of motion exercised per PT/OT two times a day for ROM exercises, arms and legs. -Blood sugar checks four times a day R1's record lacked documentation of R1's left-hand brace treatment. R1's Individualized Treatment/Therapy	01940		

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01940	Continued From page 18 Management Plan dated October 9, 2024, indicated R1 received treatments to include blood glucose monitoring, brace assistance, catheter care, compression garments, range of motion, vital signs and weight monitoring. R1's Individualized Treatment/Therapy Management Plan failed to include: -statement of the type of services that will be provided, left-hand brace -documentation of specific resident instructions relating to the treatments or therapy administration, blood glucose checks, and ROM exercises On June 4, 2025, at 9:26 a.m., regional director of nursing (RDON)-E reviewed R1's treatment plan and stated it did not include the required content as noted above. R2 R2 was admitted on March 6, 2025, with diagnoses that included hemiplegia. On June 3, 2025, at 9:03 a.m., the surveyor observed ULP-C and ULP-I assist R2 with getting dressed which included applying compression stockings to R2's lower extremities and putting R2's right arm in a sling. R2's service agreement dated March 6, 2025, indicated R2 received services to include wrist brace application/removal and heel protector application/removal. R2's service agreement did not include compression stockings or right arm sling. R2's signed prescriber orders dated March 10, 2025, included: -Wrist splint on in AM (morning) and off in PM	01940		

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01940	Continued From page 19 (evening) -Compression stockings on in MA and off in PM R2's record lacked prescriber orders for heel protectors and a right arm sling. R2's MAR dated June 2025, included: -compression socks on in AM and remove at HS (bedtime) -Right wrist splint on at HS and off at 7 AM R2's services provided document dated June 2025, included: -Heel Protectors: requires assistance applying at bedtime and removing in the morning. -Wrist Brace: apply wrist brace to right wrist every morning and remove at bedtime. R2's record lacked documentation of R2's right arm sling treatment. R2's Individualized Treatment/Therapy Management Plan dated March 6, 2025, indicated R2 received treatments to include Bed positioning devices, vital signs, weight monitoring, heel protectors and right wrist brace. R2's Individualized Treatment/Therapy Management Plan failed to include: -statement of the type of services that will be provided, right arm sling and compression stockings. On June 4, 2025, at 9:28 a.m., RDON-E reviewed R2's treatment plan and stated R2's treatment plan did not include the required content as noted above. RDON-E stated she was not aware that R2 had a right arm sling. R3	01940		

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01940	Continued From page 20 R3 was admitted on March 29, 2023, with diagnoses that included dementia and diabetes. On June 3, 2025, at 9:30 a.m., the surveyor observed R3 sitting at the dining room table with bilateral compression stockings on. ULP-D stated the staff applied the compression stockings every morning. R3's service agreement dated September 27, 2024, indicated R3 received services to include dressing, grooming, oral care, toileting, bathing, transfers, repositioning, safety checks, and medication administration. R3's service agreement did not include compression stockings. R3's signed prescriber orders dated October 21, 2024, included: -Put TED (thrombo-embolic deterrent) stockings (stockings that help prevent blood clots and swelling in legs) on in morning, and remove at bedtime R3's MAR dated June 2025, included: -Put TED stockings on in AM, Remove at HS R3's record lacked prescriber orders for blood glucose monitoring. R3's Individualized Treatment/Therapy Management Plan dated September 27, 2024, indicated R3 received treatments to include blood glucose monitoring, vital signs and weight monitoring. R3's Individualized Treatment/Therapy Management Plan failed to include: -statement of the type of services that will be provided, compression stockings.	01940		

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01940	Continued From page 21 On June 4, 2025, at 9:33 a.m., RDON-E reviewed R3's treatment plan and stated R3's treatment plan did not include the required content as noted above. The licensee's Treatment and Therapy Management Plan policy dated July 2021, indicated the following: 1. [Licensee] will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: a. A statement of the type of services that will be provided b. Documentation of specific resident instructions relating to the treatments or therapy administration c. Identification of treatment or therapy tasks that will be delegated to unlicensed personnel d. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services e. Any resident-specific requirements relating to documentation of treatment and therapy received f. Verification that all treatment and therapy was administered as prescribed g. Monitoring of treatment or therapy to prevent possible complications or adverse reactions 2. The treatment or therapy management record must be current and updated when there are any changes No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

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01960	Continued From page 22	01960		
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 document the reason they were not provided, for two of three residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 R1 was admitted on November 3, 2022, with diagnoses that included diabetes and hemiplegia (muscle weakness or partial paralysis of one side of the body).	01960		

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01960	Continued From page 23 On June 3, 2025, at 7:11 a.m., the surveyor observed unlicensed personnel (ULP)-G and ULP-H assist R1 with getting dressed which included removing R1's left wrist brace and applying compression stockings to R1's lower extremities. R1's service agreement dated October 9, 2024, indicated R1 received services to include compression stockings and diabetic management. R1's service agreement did not include range of motion (ROM) exercises or left-hand brace. R1's record lacked prescriber orders for a left hand brace. R1's record lacked documentation of R1's left-hand brace treatment. On June 4, 2025, at 9:25 a.m., regional director of nursing (RDON)-E stated R1's record lacked documentation of the ULP helping with R1's left hand brace. R2 R2 was admitted on March 6, 2025, with diagnoses that included hemiplegia. On June 3, 2025, at 9:03 a.m., the surveyor observed ULP-C and ULP-I assist R2 with getting dressed which included applying compression stockings to R2's lower extremities and putting R2's right arm in a sling. R2's service agreement dated March 6, 2025, indicated R2 received services to include wrist brace application/removal and heel protector application/removal. R2's service agreement did	01960		

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01960	Continued From page 24 not include compression stockings or right arm sling. R2's record lacked prescriber orders for right arm sling. R2's record lacked documentation of R2's right arm sling treatment. On June 4, 2025, at 9:28 a.m., RDON-E stated R2's record lacked documentation of the ULP helping with R2's right arm sling. RDON-E stated she was not aware that R2 had a right arm sling and would follow up with R2's son to see why the sling was brought in. The license's Medication and Treatment Record-Documentation and Refusal policy dated July 20, 2021, indicated documentation of medication/treatment/therapy reminders, medication treatment/therapy assistance or medication/treatment/therapy administration will be completed by the person who performed the task immediately after the medication assistance/administration 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 order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other	01970		

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SUITE LIVING SENIOR CARE OF BURNSVILLE	1880 134TH STREET EAST BURNSVILLE, MN 55337

(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 25 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 two of three residents (R1 and R2) 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 R1 was admitted on November 3, 2022, with diagnoses that included diabetes and hemiplegia (muscle weakness or partial paralysis of one side of the body). On June 3, 2025, at 7:11 a.m., the surveyor observed unlicensed personnel (ULP)-G and ULP-H assist R1 with getting dressed which included removing R1's left wrist brace and applying compression stockings to R1's lower extremities. R1's service agreement dated October 9, 2024, indicated R1 received services to include compression stockings and diabetic	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38412	A. BUILDING: _____ B. WING _____	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SENIOR CARE OF BURNSVILLE	1880 134TH STREET EAST BURNSVILLE, MN 55337

(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 management. R1's service agreement did not include range of motion (ROM) exercises or left-hand brace. R1's record lacked documentation of R1's left-hand brace treatment. R1's record lacked prescriber orders for left hand brace. On June 4, 2025, at 9:25 a.m., regional director of nursing (RDON)-E stated R1's record lacked signed prescriber orders for R1's left hand brace. R2 R2 was admitted on March 6, 2025, with diagnoses that included hemiplegia. On June 3, 2025, at 9:03 a.m., the surveyor observed ULP-C and ULP-I assist R2 with getting dressed which included applying compression stockings to R2's lower extremities and putting R2's right arm in a sling. R2's service agreement dated March 6, 2025, indicated R2 received services to include wrist brace application/removal and heel protector application/removal. R2's service agreement did not include compression stockings or a right arm sling. R2's record lacked documentation of R2's right arm sling treatment. R2's record lacked prescriber orders for a right arm sling. On June 4, 2025, at 9:28 a.m., RDON-E stated R2's record lacked prescriber orders for R2's right arm sling. RDON-E stated she was not aware	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38412	A. BUILDING: _____ B. WING _____	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SENIOR CARE OF BURNSVILLE	1880 134TH STREET EAST BURNSVILLE, MN 55337

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01970	Continued From page 27 that R2 had a right arm sling and would follow up with R2's son to see why the sling was brought in. 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		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Suite Living Senior Care
1880 134TH Street East
Burnsville, MN 55337
Dakota County
Parcel:

Phone:

License Info

License: HFID 38412

Risk:
License:
Expires on:
CFPM: Tou C Her
CFPM #: 115911; Exp: 03/31/2026

Inspection Info

Report Number: F1018251014
Inspection Type: Full - Single
Date: 6/2/2025 Time: 11:48:08 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

Viewed employee illness log and discussed pest control.

Establishment has a small kitchenette in the memory care unit with a hand sink and ice machine. No other equipment.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1018251014 from 6/2/2025

Tou Her
Kitchen Manager

Rebecca Prestwood, REHS
Public Health Sanitarian 3
651-201-3777
rebecca.prestwood@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

Suite Living Senior Care
Burnsville
County/Group: Dakota County

Inspection Info

Report Number: F1018251014
Inspection Type: Full
Date: 6/2/2025
Time: 11:48:08 AM

Food Temperature: Product/Item/Unit: Beef**; Temperature Process:** Cold-Holding
Location: Refrigerator at 39 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Fruit**; Temperature Process:** Cold-Holding
Location: Refrigerator at 39 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Cheese**; Temperature Process:** Cold-Holding
Location: Refrigerator at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Sausage**; Temperature Process:** Cold-Holding
Location: Refrigerator at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Eggs**; Temperature Process:** Cold-Holding
Location: Refrigerator at 40 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

Suite Living Senior Care
Burnsville
County/Group: Dakota County

Inspection Info

Report Number: F1018251014
Inspection Type: Full
Date: 6/2/2025
Time: 11:48:08 AM

Sanitizing Chemical: **Product:** Sink and Surface**; Sanitizing Process:** Wiping Cloth Bucket
Location: Cook Line **Equal To** 700 PPM
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Sink and Surface**; Sanitizing Process:** 3-Compartment Sink
Location: Dishwashing Area **Equal To** 700 PPM
Comment:
Violation Issued?: No

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 161 Degrees F.
Comment:
Violation Issued?: No