



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 2, 2025

Licensee

Suite Living Senior Care of Inver Grove Heights

7900 Austin Way

Inver Grove Heights, MN 55077

RE: Project Number(s) SL36603016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 10, 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 . . ."

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,



Jodi Johnson, Supervisor

State Evaluation Team

Email: Jodi.Johnson@state.mn.us

Telephone: 507-344-2730 Fax: 1-866-890-9290

KKM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER SUITE LIVING SR OF IGH			STREET ADDRESS, CITY, STATE, ZIP CODE 7900 AUSTIN WAY INVER GROVE HEIGHTS, MN 55077		
(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: SL36603016-0 On April 7, 2025, through April 10, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 31 residents; 31 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.		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food 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	0 480			

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0 480	Continued From page 2 allowed provided the facility keeps them clean 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 7, 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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0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place, information about the licensee's grievance procedure with the required content. This had the potential to affect the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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).	0 550			

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0 550	Continued From page 4 The findings include: On April 7, 2025, at 10:00 a.m. during the facility tour with clinical nurse supervisor (CNS)-B, the surveyor observed the licensee's grievance procedure posted in the entrance. Although the posted grievance procedure included the contact information for the Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, and Minnesota Adult Abuse Reporting Center (MAARC), the posting lacked the name, telephone number and email contact information for individuals who were responsible for handling resident grievances. On April 9, 2025, at 8:28 a.m., licensed assisted living director (LALD)-A reviewed the posted grievance procedure and stated it did not include the name, telephone number, or email contact for the individuals who were responsible for handling resident grievances. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person	0 630			

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0 630	Continued From page 5 and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for 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 April 31, 2022, with diagnoses that included dementia. R1's service agreement dated January 15, 2025, indicated R1 received services to include grooming, dressing, toileting assistance, bathing, transfer and ambulation assistance, safety checks, vitals, medication administration, injections, diabetic management, and oxygen management. On April 8, 2025, at 7:00 a.m., the surveyor observed unlicensed personnel (ULP)-E administer medications to R1.	0 630			

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0 630	Continued From page 6 R1's IAPP dated January 15, 2025, identified the following areas of vulnerability: -is not oriented to person, place, and time -environment is not always safe/clean R1's IAPP did not include specific interventions for the identified vulnerabilities as required. R2 R2 was admitted on February 16, 2022, with diagnosis that included diabetes and dementia. R2's service agreement dated February 19, 2025, indicated R2 received services to include grooming, dressing, toileting assistance, bathing, surgical stockings, safety checks, vitals, medication administration, and diabetic management. On April 8, 2025, at 7:21 a.m., the surveyor observed ULP-E administer medications to R2. R2's IAPP dated February 19, 2025, identified the following areas of vulnerability: -falls or frequent bruising R2's IAPP did not include specific interventions for the identified fall vulnerability as required. R3 R3 was admitted on January 24, 2024, with diagnosis that included dementia. R3's service plan dated June 11, 2024, indicated R3 received services to include grooming, dressing, toileting assistance, bathing, transfer and repositioning assistance safety checks, vitals, and medication administration.	0 630			

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0 630	Continued From page 7 On April 8, 2025, at 7:35 a.m., the surveyor observed ULP-E administer medications to R3. R3's IAPP dated March 12, 2025, identified the following areas of vulnerability: -unable to report abuse/neglect/exploitation R3's IAPP did not include specific intervention for the identified vulnerability listed above as required. On April 9, 2025, at 9:46 a.m., clinical nurse supervisor (CNS)-B reviewed R1, R2, and R3's IAPP and stated the IAPP was missing interventions for identified vulnerabilities for R1, R2, and R3. The licensee's Individual Abuse Prevention Plan policy dated July 20, 2021, indicated the plan will contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including: a. Other vulnerable adults b. The person's risk of abusing other vulnerable adults, and c. Statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 810 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	0 810			

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0 810	Continued From page 8 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training. This had the potential to directly affect all residents, staff, and visitors.	0 810			

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0 810	Continued From page 9 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: During facility tour on April 10, 2025, from 10:30 a.m. to 1:30 p.m., surveyor observed the posted evacuation plans lacked identification of resident rooms. Exit plan diagrams must be correctly labeled to reduce confusion and potential obstructions for egress in a fire or similar emergency On April 10, 2025, from 10:00 a.m. to 1:30 p.m., licensed assisted living director (LALD)-A 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's FSEP, titled "Fire Policy", dated 7/20/2021, failed to include the following: STAFF ACTIONS: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate). The provided FSEP was from a third-party provider and had not been updated to the specific facility.	0 810			

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0 810	Continued From page 10 RESIDENT ACTIONS: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. UNIQUE AND UNUSUAL RESIDENT NEEDS: The facility uses an electronic care plan website for standard resident evacuation procedures. The FSEP does not include instructions on how to use or what do in the loss of power/internet event for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. On April 10, 2025, at 12:30 p.m., LALD-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TRAINING: The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. Staff does web-based training at the time of hire, LALD-A stated they were using evacuation drills as training. No additional training documentation was provided. On April 10, 2025, at 12:30 p.m., LALD-A stated they understood the requirements for training of staff and would implement a training program that was compliant with statute requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			

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01620	Continued From page 11	01620			
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted timely ongoing nursing assessments 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	01620			

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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
01620	Continued From page 12 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 April 31, 2022, with diagnoses that included dementia. R1's service agreement dated January 15, 2025, indicated R1 received services to include grooming, dressing, toileting assistance, bathing, transfer and ambulation assistance, safety checks, vitals, medication administration, injections, diabetic management, and oxygen management. R1's assessments dated August 15, 2024, November 5, 2024, and January 15, 2025, were reviewed. The November 5, 2024, assessment was completed 92 days after the date of the previous assessment, thus exceeding 90 calendar days. R2 R2 was admitted on February 16, 2022, with diagnosis that included diabetes and dementia. R2's service agreement dated February 19, 2025, indicated R2 received services to include grooming, dressing, toileting assistance, bathing, surgical stockings, safety checks, vitals, medication administration, and diabetic management.	01620			

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01620	Continued From page 13 R2's assessments dated August 16, 2024, November 15, 2024, and February 19, 2025, were reviewed. The November 15, 2024, assessment was completed 91 days after the date of the previous assessment, thus exceeding 90 calendar days. The February 19, 2025, assessment was completed 96 days after the date of the previous assessment, thus exceeding 90 calendar days. R3 R3 was admitted on January 24, 2024, with diagnosis that included dementia. R3's service plan dated June 11, 2024, indicated R3 received services to include grooming, dressing, toileting assistance, bathing, transfer and repositioning assistance safety checks, vitals, and medication administration. R3's assessments dated September 10, 2024, December 9, 2024, and March 12, 2025, were reviewed. The March 12, 2025, assessment was completed 93 days after the date of the previous assessment, thus exceeding 90 calendar days. On April 9, 2025, at 9:44 a.m., clinical nurse supervisor (CNS)-B stated R1, R2 and R3's assessments were not completed within the required time frame. The licensee's Assessments, Reviews and Monitoring policy dated August 1, 2021, 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	01620			

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01620	Continued From page 14 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 (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	01640			

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01640	Continued From page 15 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 found to be pervasive). The findings include: R1 R1 was admitted on April 31, 2022, with diagnoses that included dementia. R1's service agreement dated January 15, 2025, indicated R1 received services to include grooming, dressing, toileting assistance, bathing, transfer and ambulation assistance, safety checks, vitals, medication administration, injections, diabetic management, and oxygen management. The service agreement was not signed by R1, R1's representative or the licensee. On April 8, 2025, at 10:22 a.m., clinical nurse supervisor stated R1 did not receive diabetic management services (despite the service agreement indicating otherwise). R2 R2 was admitted on February 16, 2022, with diagnosis that included diabetes and dementia. R2's service agreement dated February 19, 2025,	01640			

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01640	Continued From page 16 indicated R2 received services to include grooming, dressing, toileting assistance, bathing, surgical stockings, safety checks, vitals, medication administration, and diabetic management. On April 8, 2025, at 10:09 a.m., CNS-B stated R2 no longer received assistance with surgical stockings (despite the service agreement indicating otherwise). R3 R3 was admitted on January 24, 2024, with diagnosis that included dementia. On April 8, 2025, at 7:35 a.m., the surveyor observed R3 sitting in her wheelchair and had bilateral compression stockings on. Unlicensed personnel (ULP)-E stated the staff applied the compression stockings every morning. R3's service plan dated June 11, 2024, indicated R3 received services to include grooming, dressing, toileting assistance, bathing, transfer and repositioning assistance safety checks, vitals, and medication administration. The service agreement did not include compression stockings and was not signed by R3, R3's representative, or the licensee. On April 8, 2026, at 10:26 a.m., regional director of nursing (RDON)-C and CNS-B reviewed R1, R2 and R3's service agreements and stated the service plans did not accurately reflect the current services being provided. RDON-C stated R1 and R3's service agreements were sent to their representatives to be signed; however, they were not returned. The licensee's Service Plan policy dated July 20,	01640			

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01640	Continued From page 17 2021, 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 safety but had the potential to have harmed a	01750			

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01750	Continued From page 18 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 April 31, 2022, with diagnoses that included dementia. R1's service agreement dated January 15, 2025, indicated R1 received services to include medication administration. R1's medication administration record (MAR) dated April 2025, included the following medications: -bisacodyl suppository 10 mg; insert one suppository rectally as needed (constipation), prescriber order dated February 4, 2025 -milk of magnesia suspension; give 30 ml by mouth every day as needed (constipation), prescriber order dated February 4, 2025 -Miralex 17 grams (gm); give 17 gm by mouth every day as needed (constipation), prescriber order dated July 3, 2024 R2 R2 was admitted on February 16, 2022, with diagnosis that included diabetes and dementia. R2's service agreement dated February 19, 2025, indicated R2 received services to include medication administration. R2's MAR dated April 2025, included the following	01750			

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01750	Continued From page 19 medications: -bisacodyl suppository 10 mg; insert one suppository rectally as needed (constipation), prescriber order dated February 4, 2025 -milk of magnesia suspension; give 30 ml by mouth every day as needed (constipation), prescriber order dated February 4, 2025 R3 R3 was admitted on January 24, 2024, with diagnosis that included dementia. R3's service plan dated June 11, 2024, indicated R3 received services to include medication administration. R3's MAR dated April 2025, included the following medications: -bisacodyl suppository 10 mg; insert one suppository rectally as needed (constipation), prescriber order dated February 4, 2025 -milk of magnesia suspension; give 30 ml by mouth every day as needed (constipation), prescriber order dated February 4, 2025 -senna s 8.6-50 mg; give one tablet by mouth every 12 hours as needed (constipation), prescriber order dated June 6, 2024 The licensee failed to provide instructions for the ULP to understand which PRN (as needed) medication for constipation should be used in which order for R1, R2 and R3. 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	01750			

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01750	Continued From page 20 management or treatment/therapy services will be provided and how those services will be 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			
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to renew prescriptions at least every 12 months 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	01830			

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01830	Continued From page 21 a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 R1 was admitted on April 31, 2022, with diagnoses that included dementia. R1's service agreement dated January 15, 2025, indicated R1 received services to include medication administration. R1's record lacked evidence of prescriber orders being renewed annually for the following medications: -aspirin 81 milligrams (mg); give one tablet by mouth in the morning (heart health), prescriber order dated May 5, 2023 -calcium 600 mg; give one tablet by mouth in the morning (supplement), prescriber order dated May 5, 2023 -magnesium chloride 64 mg; give two tablets by mouth one time a day (supplement), prescriber order dated June 1, 2023 -melatonin 3 mg; give one tablet by mouth at bedtime (sleep), prescriber order dated May 5, 2023 -Refresh Tears; Instill one drop in both eyes two times a day (dry eyes), prescriber order dated January 2, 2024 R2 R2 was admitted on February 16, 2022, with diagnosis that included diabetes and dementia. R2's service agreement dated February 19, 2025, indicated R2 received services to include medication administration.	01830			

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01830	Continued From page 22 R2's record lacked evidence of prescriber orders being renewed annually for the following medication: -sodium bicarbonate 650 mg; give one tablet by mouth two times a day (heartburn), prescriber order February 13, 2024 On April 8, 2025, at 2:07 p.m., regional director of nursing (RDON)-C stated R1 and R2's records lacked evidence of prescriber orders being renewed annually for the medications listed above. The License's Medication and Treatment Orders policy dated July 20, 2021, indicated the licensed nurse would communicate with the prescriber to assure that the prescriber renews a medication or treatment/therapy order at least every 12 months, or more frequently as needed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all medications were securely locked in substantially constructed compartments and permitted only	01880			

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01880	Continued From page 23 authorized personnel to have access. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 7, 2025, at approximately 9:30 am. during the entrance conference, clinical nurse supervisor (CNS)-B stated medications were stored in locked medication carts. During this time, the surveyor observed an unlocked, unattended medication cart in the memory care unit. Several residents were sitting in the common living space near the unlocked medication cart. CNS-B locked the medication cart and stated she expected the medications carts to be locked any time staff were not present. The licensee's Medication Storage policy dated July 2021, indicated when medications were managed and stored by the licensee, medications would be kept securely locked and stored per manufacturer's direction. Only authorized staff would have access to stored medications. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01890 SS=D	144G.71 Subd. 20 Prescription drugs	01890			

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01890	Continued From page 24 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: Based on observation, interview, and record review, the licensee failed to ensure accurate labeling for one of three residents (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: R2 R2 was admitted on February 16, 2022, with diagnosis that included diabetes and dementia. R2's service agreement dated February 19, 2025, indicated R2 received services to include medication administration. R2's signed prescriber orders dated March 11, 2025, included: -Insulin glargine; inject 7 units subcutaneously two times a day (diabetes) On April 8, 2025, at 7:50 a.m., the surveyor	01890			

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01890	Continued From page 25 observed unlicensed personnel (ULP)-E administer 7 units of insulin glargine to R2. The prescription label on the insulin glargine indicated to administer 8 units. The prescription label did not match the current prescriber order. On April 9, 2025, at 9:51 a.m., clinical nurse supervisor (CNS)-B stated R2's dose was recently changed and there should have been a "directions changed refer to chart" sticker applied to the prescription label. The licensee's Medications - Prescribed, Not Prescribed & OTC (over the counter) policy dated revised July 20, 2021, noted the licensee providing medication management services must retain items in the original labeled container with directions for use prior to setting up for immediate or later administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state	01910			

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NAME OF PROVIDER OR SUPPLIER SUITE LIVING SR OF IGH		STREET ADDRESS, CITY, STATE, ZIP CODE 7900 AUSTIN WAY INVER GROVE HEIGHTS, MN 55077			
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01910	Continued From page 26 and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one discharged resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R4 was admitted to the licensee on September 7, 2022, and discharged on February 10, 2025. R4's Medication Administration Record (MAR) dated February 2025, indicated R4 received the following medications: -alendronate sodium 70 milligrams (mg); give one tablet by mouth one time a day every Wednesday (osteoporosis) -atorvastatin 40 mg; give one tablet by mouth at bedtime (cholesterol)	01910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER SUITE LIVING SR OF IGH			STREET ADDRESS, CITY, STATE, ZIP CODE 7900 AUSTIN WAY INVER GROVE HEIGHTS, MN 55077		
(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	
01910	Continued From page 27 -Breo Ellipta Inhalation; 100-25 micrograms (mcg); one puff inhale orally in the morning (emphysema) -calcium citrate 1000 mg; give one tablet by mouth one time a day (supplement) -diazepam 2 mg; give two tablets by mouth at bedtime (schizoaffective disorder) -Lasix 40 mg; give one tablet by mouth one time a day (diuretic) -loperamide 2 mg; give two tablets by mouth one time a day (loose stools) -pantoprazole sodium 20 mg; give one tablet by mouth in the morning (reflux) -spironolactone 25 mg; give one tablet by mouth one time a day (heart disease) -trazodone 150 mg; give one tablet by mouth at bedtime (sleep) -Vitamin D 25 mcg; give one tablet by mouth one time a day (supplement) -Xarelto 20 mg; give one tablet by mouth in the evening (heart disease) -Nystatin powder 100000 unit/gram (g); apply under breast topically two times a day (rash) -olanzapine 5 mg; give one tablet by mouth every morning and at bedtime (agitation) -acetaminophen 500 mg; give two tablets by mouth three times a day (pain) -albuterol sulfate; two puffs inhale orally every six hours as needed (shortness of breath) -antacid calcium 500 mg; give two tablets by mouth every one hour as needed (heartburn) -aspirin 325 mg; give one tablet by mouth as needed (chest pain) -bisacodyl laxative suppository 10 mg; insert one suppository rectally as needed (constipation) -Claritin 10 mg; give one tablet by mouth every 24 hours as needed (nasal congestion, cold like symptoms) -Diclofenac sodium gel 1%; apply to right shoulder topically as needed (shoulder pain)	01910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER SUITE LIVING SR OF IGH			STREET ADDRESS, CITY, STATE, ZIP CODE 7900 AUSTIN WAY INVER GROVE HEIGHTS, MN 55077		
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01910	Continued From page 28 -Flonase suspension 50 mcg; two sprays in both nostrils as needed (allergies) -guaifenesin 400 mg; give one tablet by mouth every six hours as needed (congestion) -guaifenesin solution 100 mg/10 milliliter (ml): give 10 ml by mouth every four hours as needed (cough) -hydrocortisone cream 1%; apply to affected skin area topically as needed (rash) -loperamide 2 mg; give two tablets by mouth as needed (loose stools) -menthol cough drops lozenge; give one lozenge by mouth every one hour as needed (cough) -milk of magnesia; give 30 ml by mouth every 24 hours as needed (constipation) -nitroglycerin; give one tablet sublingually as needed for chest pain. -olanzapine 2.5 mg; give one tablet by mouth every 24 hours as needed (agitation) -Senna-S 8.6-50 mg; give one tablet by mouth as needed (constipation) -tramadol 50 mg; give one half tablet by mouth as needed for pain relief three times a day as needed. R4's record lacked a medication disposition record at the time of discharge to include the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. On April 8, 2025, at 10:35 a.m., regional director of nursing (RDON)-C stated R4's record should have included a disposition of medications; however, it could not be located. The licensee's Medication Disposal policy dated August 1, 2021, indicated the following:	01910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER SUITE LIVING SR OF IGH			STREET ADDRESS, CITY, STATE, ZIP CODE 7900 AUSTIN WAY INVER GROVE HEIGHTS, MN 55077		
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01910	Continued From page 29 -current unused medications managed by [licensee] will be returned to the pharmacy for credit, if able, or given to the resident or resident's representative, when the resident's medications are no longer managed by the facility or the medication has been discontinued by the provider. -upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			
01940 SS=D	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	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2025
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01940	Continued From page 30 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 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 two of three residents (R1 and R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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 April 31, 2022, with diagnoses that included dementia. R1's service agreement dated January 15, 2025,	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2025
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01940	Continued From page 31 indicated R1 received services to include vital signs, medication administration, diabetic management, and oxygen management. On April 8, 2025, at 7:14 a.m., the surveyor observed R1 sitting in her recliner with oxygen on at 1 liter per nasal cannula. Unlicensed personnel (ULP)-E assisted R1 with switching R1's oxygen from the concentrator to a portable tank. ULP-E set oxygen for the portable tank to 1.5 liters per nasal cannula. ULP-E stated R1's oxygen was set at 1 liter when resting and 1.5 liters when she was up and moving around. R1's signed prescriber orders dated February 3, 2025, included the following order for oxygen: -Oxygen at 2 liters per minute (LPM) at rest and 2.5 LPM with activity via nasal cannula. R1's individualized treatment/therapy management plan dated January 15, 2025, failed to include -statement of the type of services that will be provided, oxygen management. R3 R3 was admitted on January 24, 2024, with diagnosis that included dementia. On April 8, 2025, at 7:35 a.m., the surveyor observed R3 sitting in her wheelchair and had bilateral compression stockings on. ULP-E stated the staff applied the compression stockings every morning. R3's service plan dated June 11, 2024, indicated R3 received services to include grooming, dressing, toileting assistance, bathing, transfer and repositioning assistance safety checks, vitals, and medication administration. The service	01940			

Minnesota Department of Health

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01940	Continued From page 32 agreement did not include compression stockings. R3's signed prescriber orders dated February 19, 2025, indicated the following: -Compression stockings; apply to lower legs in the morning and off in the evening R3's medication administration record (MAR) dated April 2025, indicated staff applied R3's compression stockings every morning and removed the stockings every evening. R3's individualized treatment/therapy management plan dated January 15, 2025, failed to include -statement of the type of services that will be provided, compression stockings. On April 8, 2025, at 10:25 a.m., clinical nurse supervisor (CNS)-B and regional director of nursing (RDON)-C reviewed R1 and R3's individualized treatment/therapy plans and stated they did not include the treatment services as listed above. The licensee's Treatment and Therapy Management Plan policy dated August 1, 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	01940			

Minnesota Department of Health

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01940	Continued From page 33 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			
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 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 interview and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were renewed at least every 12 months for two of three residents (R1 and R2) receiving treatments.	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2025
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01970	Continued From page 34 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 April 31, 2022, with diagnoses that included dementia. R1's service agreement dated January 15, 2025, indicated R1 received services to include vitals, medication administration, diabetic management, and oxygen management. R1's signed prescriber orders dated February 3, 2025, included the following order for oxygen: -Oxygen at 2 liters per minute (LPM) at rest and 2.5 LPM with activity via nasal cannula. On April 8, 2025, at 7:14 a.m., the surveyor observed R1 sitting in her recliner with oxygen on at 1 liter per nasal cannula. Unlicensed personnel (ULP)-E assisted R1 with switching R1's oxygen from the concentrator to a portable tank. ULP-E set oxygen for the portable tank to 1.5 liters per nasal cannula. ULP-E stated R1's oxygen was set at 1 liter when resting and 1.5 liters when she was up and moving around. ULP-E pointed to a document on R1's bathroom door that indicated "1 L at rest, 1.5 L activity, breathe in thru nose, out thru mouth". On April 8, 2025, at 10:08 a.m., clinical nurse	01970			

Minnesota Department of Health

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01970	Continued From page 35 supervisor (CNS)-B stated the staff should follow the prescriber orders for administering oxygen. CNS-B stated she thought therapy may have written the document on R1's bathroom door which did not match the current prescriber orders for oxygen. CNS-B stated she would notify the provider and obtain clarification. R2 R2 was admitted on February 16, 2022, with diagnosis that included diabetes and dementia. R2's service agreement dated February 19, 2025, indicated R2 received services to include grooming, dressing, toileting assistance, bathing, surgical stockings, safety checks, vitals, medication administration, and diabetic management. On April 8, 2025, at 10:09 a.m., CNS-B stated R2 no longer received assistance with surgical stockings. R2's signed prescriber orders dated March 21, 2023, included: -check blood sugar before meals and at bedtime R2's record did not include a current order within the past 12 months for blood sugar checks. On April 8, 2025, at 2:08 p.m., regional director of nursing (RDON)-C stated R2's record lacked a current order within the past 12 months for blood sugar checks. The licensee's Medication and Treatment Orders policy dated July 20, 2021, the licensed nurse would communicate with the prescriber to assure that the prescriber renews a medication or treatment/therapy order at least every 12 months,	01970			

Minnesota Department of Health

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01970	Continued From page 36 or more frequently as needed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970			

Type: Full
Date: 04/07/25
Time: 11:30:00
Report: 1004251081

Food and Beverage Establishment Inspection Report

Page 1

Location:

Suite Living Sr Of Igh
7900 Austin Way
Inver Grove Heights, MN55077
Dakota County, 19

Establishment Info:

ID #: 0038802
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6517702273
ID #:

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

The following orders were issued during this inspection.

4-900 Protecting Clean Items**4-904.11A**

MN Rule 4626.0965A Handle, display, and dispense all single-service and single use articles and clean utensils so that contamination of lip-contact and food-contact surfaces is prevented.

PLASTIC UTENSILS FOUND STORED FACING DIFFERENT DIRECTIONS IN THE KITCHEN PASS-THROUGH WINDOW. ENSURE PLASTIC UTENSILS ARE STORED FACING THE SAME DIRECTION TO PREVENT HAND-CONTACT WITH THE LIP/FOOD-CONTACT PORTION OF THE UTENSIL.

Comply By: 04/07/25

Surface and Equipment Sanitizers

Wash Temp. Gauge: = at 170 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Rinse Temp. Gauge: = at 185 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Utensil Surface Temp.: = at 161 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Lactic Acid: = 704PPM at Degrees Fahrenheit
Location: DISPENSER
Violation Issued: No

Lactic Acid: = 704PPM at Degrees Fahrenheit
Location: SPRAY BOTTLE
Violation Issued: No

Type: Full
Date: 04/07/25
Time: 11:30:00
Report: 1004251081
Suite Living Sr Of Igh

Food and Beverage Establishment
Inspection Report

Lactic Acid: = 704PPM at Degrees Fahrenheit
Location: SPRAY BOTTLE
Violation Issued: No

Lactic Acid: = 704PPM at Degrees Fahrenheit
Location: SPRAY BOTTLE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: HAM
Temperature: 37 Degrees Fahrenheit - Location: 2-DOOR COOLER (BACK)
Violation Issued: No

Process/Item: CUT LETTUCE
Temperature: 37 Degrees Fahrenheit - Location: 2-DOOR COOLER (BACK)
Violation Issued: No

Process/Item: CHEESE
Temperature: 39 Degrees Fahrenheit - Location: 2-DOOR COOLER (FRONT)
Violation Issued: No

Process/Item: SOUP
Temperature: 38 Degrees Fahrenheit - Location: 2-DOOR COOLER (FRONT)
Violation Issued: No

Process/Item: RICE
Temperature: 194 Degrees Fahrenheit - Location: STEAM WELL
Violation Issued: No

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

INSPECTION WAS CONDUCTED BY MOLLY DOUGHERTY (FPLS) IN CONJUNCTION WITH A HEALTH REGULATIONS DIVISION (HRD) SURVEY CONDUCTED BY KASSIE MARKING.

- DISCUSSED:
- EMPLOYEE ILLNESS POLICY AND LOG
 - HANDWASHING
 - SANITIZER USE AND TEST KITS
 - SPRAY BOTTLE LABELING
 - CLEANING/SANITIZING FOOD CONTACT SURFACES AND UTENSILS
 - HIGH TEMPERATURE SANITIZING DISH MACHINE TEMPERATURE VERIFICATION
 - DATE MARKING PROCEDURES
 - THERMOMETER USE AND CALIBRATION
 - SERVING A HIGHLY SUSCEPTIBLE POPULATION (NO RAW/UNDERCOOKED ANIMAL FOODS, NO UNPASTEURIZED JUICE, MILK, ETC)
 - VOMIT/FECAL INCIDENT CLEAN UP PROCEDURES
 - FOOD SOURCE
 - RECEIVING DELIVERIES PROCEDURES
 - FOOD SERVICE PROCEDURES
 - PEST CONTROL
 - PHYSICAL FACILITIES AND MAINTENANCE

Type: Full
Date: 04/07/25
Time: 11:30:00
Report: 1004251081
Suite Living Sr Of Igh

Food and Beverage Establishment Inspection Report

*REPORT WAS DISCUSSED WITH THE CHEF, NATAJA, THE DIRECTOR, HEATHER, AND WITH THE NURSE EVALUATOR, KASSIE.

*IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE RESIDENT. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

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 1004251081 of 04/07/25.

Certified Food Protection Manager: NATAJA W. NELSON

Certification Number: FM45308 Expires: 08/13/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
NATAJA NELSON

Signed: Molly Dougherty
Molly Dougherty
Public Health Sanitarian
Metro District Office
651-201-3978
molly.dougherty@state.mn.us