Electronically Delivered

February 6, 2024

Licensee
Suite Living Senior Care Of Shakopee, LLC
1645 Windermere Way
Shakopee, MN 55379

RE: Project Number(s) SL39570015

Dear Licensee:

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

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

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

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

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

**CORRECTION ORDER RECONSIDERATION PROCESS**

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

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

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

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

If you have any questions, please contact me.

Sincerely,

Kelly Thorson, Supervisor
SState Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

PMB

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 39570 | A. BUILDING: _____ B. WING _____ | 01/10/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SUITE LIVING SENIOR CARE OF SHAKOPEE L | 1645 WINDERMERE WAY SHAKOPEE, MN 55379 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.<br><br>INITIAL COMMENTS:<br>SL39570015<br><br>On January 8, 2024, through January 10, 2024, 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 14 residents; all receiving services under the Assisted Living with Dementia Care license. | 0 000 | Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3. | |
| 0 660 SS=D | 144G.42 Subd. 9 Tuberculosis prevention and control<br><br>(a) The facility must establish and maintain a | 0 660 | | |

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| 0 660 | Continued From page 1<br><br>comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.<br>(b) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included TB training for one of two facility staff, licensed practical nurse (LPN)-B.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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).<br><br>The findings include:<br><br>LPN-B began employemnt on September 18, 2023, as the care manager. | 0 660 | | |

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| 0 660 | Continued From page 2<br><br>LPN-B's training records did not include training regarding TB.<br><br>On January 9, 2024, at 3:00 p.m., licensed assisted living director (LALD)-A stated the infection control education module which covers TB, is normally assigned to each new staff member in Educare (online training platform). LALD-A further stated she is not sure why that class had not been assigned to LPN-B at the time of hire.<br><br>The facility TB Risk Assessment worksheet dated January 5, 2023, indicated the risk level of TB is low.<br><br>The licensee's Tuberculosis Screening policy dated July 20, 2021, indicated staff would be educated regarding TB at the time of hire and annually.<br><br>The Minnesota Department of Health guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include an annual facility TB risk assessment. The guidelines also indicated an employee may begin working with patients [residents] after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employee's record.<br><br>No further information was provided. | 0 660 | | |

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| 0 660 | Continued From page 3<br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 660 | | |
| 0 700 SS=F | 144G.43 Subdivision 1 Resident record<br><br>(b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to ensure resident records were protected against unauthorized disclosure of electronic records.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>On January 10, 2024, at 8:00 a.m., the surveyor observed a laptop computer sitting on top of the medication cart. The computer screen was left open/unsecured with resident information showing on the screen. No staff or residents were present at the time. | 0 700 | | |

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| 0 700 | Continued From page 4<br><br>On January 10, 2024, at 1:30 p.m., licensed practical nurse (LPN)-B stated staff are trained to lock the computer screen any time they are not in front of it or if they must walk away.<br><br>On January 10, 2024, at 1:35 p.m., unlicensed personnel (ULP)-F stated she was trained to lock the computer screen any time she walks away. ULP-F further stated she did not lock the computer screen that morning because she was running behind and just forgot but is usually good about securing her computer.<br><br>The licensee's Resident Record-Confidentiality policy dated July 19, 2021, indicated resident records will be kept confidential and locked in a secure area where only authorized staff of [the facility] have access to. All staff are responsible to make sure confidentiality is maintained for all resident records and information.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 700 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and | 0 810 | | |

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| 0 810 | Continued From page 5<br><br>(4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.<br>(c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.<br>(f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to develop a fire safety and evacuation plan with the required elements, failed to provide required employee training on fire safety and evacuation, and failed to conduct required evacuation drills as required. This had the potential to affect all staff, residents, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to | 0 810 | | |

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| 0 810 | Continued From page 6<br><br>cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On January 9, 2024, at 10:00 p.m., licensed assisted living director (LALD)-A and housing director (HD)-E provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility.<br><br>FIRE SAFETY AND EVACUATION PLAN<br>The posted emergency evacuation plan did not show the number of resident rooms.<br><br>During the interview on January 9, 2024, at 11:00 a.m., HD-E verified the facility needed to update the fire safety and evacuation plan with the number of resident rooms.<br><br>TRAINING<br>Record review of the available documentation indicated employees did not receive training twice per year after initial hire.<br><br>During the interview on January 9, 2024, at 11:00 a.m., LALD-A stated the licensee provided annual training on the fire safety and evacuation plan to employees, but not twice per year after the initial hire, as required by statute. LALD-A confirmed there was no further documented training for the staff on the fire safety and evacuation plan as required by statute.<br><br>DRILLS<br>Record review of the available documentation | 0 810 | | |

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| 0 810 | Continued From page 7<br><br>indicated that evacuation drills for employees had not been performed every other month as required. Provided documentation indicated that the drills were conducted on 3/13/23 for the p.m. shift, 5/18/23 for the night shift, 7/12/23 for the a.m. shift, and 9/27/23 for the p.m. shift, with no further drills being documented.<br><br>During the interview on January 9, 2024, at 11:00 a.m., HD-E stated that she was hired in October 2023 and the facility had not conducted any fire drills since September 2023.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 810 | | |
| 01370 SS=D | 144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn<br><br>(a) Training and competency evaluations for all unlicensed personnel must include the following:<br>(1) documentation requirements for all services provided;<br>(2) reports of changes in the resident's condition to the supervisor designated by the facility;<br>(3) basic infection control, including blood-borne pathogens;<br>(4) maintenance of a clean and safe environment;<br>(5) appropriate and safe techniques in personal hygiene and grooming, including:<br>(i) hair care and bathing;<br>(ii) care of teeth, gums, and oral prosthetic devices;<br>(iii) care and use of hearing aids; and<br>(iv) dressing and assisting with toileting;<br>(6) training on the prevention of falls;<br>(7) standby assistance techniques and how to perform them; | 01370 | | |

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| 01370 | Continued From page 8<br><br>(8) medication, exercise, and treatment reminders;<br>(9) basic nutrition, meal preparation, food safety, and assistance with eating;<br>(10) preparation of modified diets as ordered by a licensed health professional;<br>(11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family;<br>(12) awareness of confidentiality and privacy;<br>(13) understanding appropriate boundaries between staff and residents and the resident's family;<br>(14) procedures to use in handling various emergency situations; and<br>(15) awareness of commonly used health technology equipment and assistive devices.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure required training was completed for one of two employees (unlicensed personnel (ULP)-C).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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).<br><br>The findings include:<br><br>ULP-C began employemnt on October 18, 2023, to provide direct care services. ULP-C was | 01370 | | |

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| 01370 | Continued From page 9<br>observed providing direct care services to residents on January 9 and January 10, 2024.<br><br>ULP-C's employee record lacked documentation of the following required training to be completed by ULP:<br>-documentation requirements for all services provided<br>-reports of changes in the resident's condition to the supervisor designated by the facility<br>-training on the prevention of falls for providers working with the elderly or individuals at risk of falls<br>-communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; and<br>-understanding appropriate boundaries between staff and residents and the resident's family.<br><br>On January 10, 2024, at 9:10 a.m., licensed practical nurse (LPN)-B stated she had been given all the training records for ULP-C so anything that was missing was not assigned in Educare (online education platform) and did not know why certain items were missed.<br><br>The licensee's Competency Training Evaluations policy dated July 20, 2021, indicated:<br>Training and competency evaluations for all ULP's will include:<br>-Documentation requirements for all services provided<br>-Reports of changes in the resident's condition to the supervisor designated by the facility<br>-Training on the prevention of falls<br>-Communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family | 01370 | | |

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| 01370 | Continued From page 10<br>-Awareness of confidentiality and privacy<br>-Understanding appropriate boundaries between staff and residents and the resident's family<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01370 | | |
| 01470 SS=D | 144G.63 Subd. 2 Content of required orientation<br><br>(a) The orientation must contain the following topics:<br>(1) an overview of this chapter;<br>(2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;<br>(3) handling of emergencies and use of emergency services;<br>(4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);<br>(5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;<br>(7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;<br>(8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human | 01470 | | |

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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 |
|---|---|---|---|---|
| 01470 | Continued From page 11<br><br>Services, county-managed care advocates, or other relevant advocacy services; and<br>(9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure.<br>(b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:<br>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;<br>(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or<br>(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure orientation to assisted living facility licensing requirements and regulations included all required content for one of two employees (licensed practical nurse (LPN-B).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to | 01470 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 39570 | A. BUILDING: _____ B. WING _____ | 01/10/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUITE LIVING SENIOR CARE OF SHAKOPEE L | 1645 WINDERMERE WAY SHAKOPEE, MN 55379 |

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|---|---|---|---|---|
| 01470 | Continued From page 12<br><br>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).<br><br>The findings include:<br><br>LPN-B began employemnt on September 18, 2023.<br><br>LPN-B's employee record lacked the following required orientation content:<br>-overview of assisted living statutes<br>-review of provider's policies and procedures<br>-handling of resident complaints, reporting of complaints, where to report<br>-consumer advocacy services<br>-review of types of assisted living services the employee will provide and provider's scope of license<br><br>On January 9, 2024, at 3:00 p.m., licensed assisted living director (LALD)-A stated the Educare (online education platform) class that covers the orientation requirement is usually automatically assigned and she was not sure why this class was not assigned upon hire for LPN-B.<br><br>The licensee's Orientation of Staff and Supervisors & Content policy dated July 20, 2021, indicated all staff of [the facility] providing and supervising direct services must complete an orientation to Assisted Living facility licensing requirements and regulations before providing assisted living services to residents. The orientation must contain the following topics: an overview of the appropriate assisted living statutes and rules, an introduction and review of the facility's policies and procedures related to the | 01470 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 39570 | A. BUILDING: _____ B. WING _____ | 01/10/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUITE LIVING SENIOR CARE OF SHAKOPEE L | 1645 WINDERMERE WAY SHAKOPEE, MN 55379 |

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|---|---|---|---|---|
| 01470 | Continued From page 13<br><br>provision of assisted living services by the individual staff, handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints, consumer advocacy services, and a review of the types of assisted living services the employee will be providing and the facility's category of licensure.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01470 | | |
| 01890 SS=F | 144G.71 Subd. 20 Prescription drugs<br><br>A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to monitor for expired medications and failed to keep a medication in its original container bearing the original prescription label.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic | 01890 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 39570 | A. BUILDING: _____ B. WING _____ | 01/10/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| 01890 | Continued From page 14<br>failure that has affected or has potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>On January 9, 2024, at 8:00 a.m., the surveyor observed the medication cart in the memory care unit. There was one bottle of Rybelsus (used to treat type 2 diabetes) 14 mg tablets which was missing a pharmacy label and had an expiration date stamped on the bottle of December 31, 2023.<br><br>On January 9, 2024, at 8:05 a.m., unlicensed personnel (ULP)-C stated she was trained to check expiration dates and should have checked it. ULP-C further stated others must not have been checking it either as it had been given daily for nine days past its expiration date.<br><br>On January 9, 2024, at 8:20 a.m., licensed practical nurse (LPN)-B stated they train staff to look at expiration dates on medications. LPN-B further stated she was surprised the bottle was expired because they got it from the pharmacy less than a year ago. LPN-B stated the bottle came in a box which had the pharmacy label and did not know where the box was.<br><br>The licensee's Medication-Prescription Drugs & Prohibition policy dated July 21, 2021, indicated when [the facility] receives a prescription drug, prior to being set up for immediate or later administration, the prescription drug 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. | 01890 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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|---|---|---|---|---|
| 01890 | Continued From page 15<br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: seven (7) days | 01890 | | |
| 02310 SS=F | 144G.91 Subd. 4 (a) Appropriate care and services<br><br>(a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical, or nursing standards for one of two residents (R5) who utilized oxygen.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>On January 9, 2024, at 11:30 a.m., the surveyor observed an oxygen tank stored in R5's room unsecured. The small oxygen tank was standing next to the oxygen refill station.<br><br>On January 9, 2024, at 11:35 a.m., licensed | 02310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 39570 | A. BUILDING: _____ B. WING _____ | 01/10/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SUITE LIVING SENIOR CARE OF SHAKOPEE L | 1645 WINDERMERE WAY SHAKOPEE, MN 55379 |

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|---|---|---|---|---|
| 02310 | Continued From page 16<br><br>practical nurse (LPN)-B stated oxygen was ordered by hospice in case it was needed. It had not been used. LPN-B stated she did not know the tank was not secure and will ask the hospice nurse about it.<br><br>Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated April 16, 2020, recommended cylinders be secured with chains or racks to prevent cylinders from falling over.<br><br>The licensee's Oxygen policy dated July 20, 2021, indicated, when possible, keep oxygen cylinders and vessels a minimum of five feet from electrical appliances. Oxygen cylinders and vessels must remain upright at all times.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 02310 | | |

Minnesota Department of Health
Food, Pools and Lodging Services Section
625 N Robert St
St Paul, MN 55164
651-201-4500

Type: Full
Date: *01/09/24*
Time: 13:29:11
Report: 7963241005

# Food and Beverage Establishment Inspection Report



**Location:**

Suite Living of Shakopee
1645 Windemere Way
Shakopee, MN55379
Scott County, 70

**Establishment Info:**

ID #: N010924
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #:
ID #:

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

No NEW orders were issued during this inspection.

**Surface and Equipment Sanitizers**

Acid: = 700ML at Degrees Fahrenheit
Location: SANI BUCKET
Violation Issued: No

Hot Water: = at 163 Degrees Fahrenheit
Location: DISHWASHER RINSE
Violation Issued: No

**Food and Equipment Temperatures**

Process/Item: MILK
Temperature: 39 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: SL TURKEY
Temperature: 38 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: CUT WATERMELON
Temperature: 38 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: MASHED POTATOES
Temperature: 178 Degrees Fahrenheit - Location: HOT HOLDING
Violation Issued: No

Process/Item: SLICED TURKEY
Temperature: 170 Degrees Fahrenheit - Location: HOT HOLDING
Violation Issued: No

Type: Full
Date: *01/09/24*
Time: 13:29:11
Report: 7963241005
Suite Living of Shakopee

# Food and Beverage Establishment Inspection Report

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

MET WITH HRD SURVEYOR WENDY ROBARGE, HOUSING DIRECTOR MANU TOGBAH AND KITCHEN MANAGER KAREN PERRIER.

DISCUSSED THE FOLLOWING-

-EMPLOYEE ILLNESS POLICY AND LOG
-REPORTABLE DISEASES
-VOMIT/FECAL CLEAN UP
-SANITIZER CONCENTRATIONS

THIS ESTABLISHMENT HAS A COMMERCIAL KITCHEN SPACE.

**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 7963241005 of 01/09/24.

Certified Food Protection Manager: Karen Perrier

Certification Number: FM 75407 Expires: 10/26/25

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

Signed: _____

Manu Togbah
Housing Director

Signed: Peggy Spadafore

Peggy Spadafore
Sanitarian Supervisor
metro
651-201-4500
peggy.spadafore@state.mn.us

Report #: 7963241005

# Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools and Lodging Services Section
625 N Robert St
St Paul, MN 55164

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

Date 01/09/24
Time In 13:29:11
Time Out

| | Address | City/State | Zip Code | Telephone |
|---|---|---|---|---|
| Suite Living of Shakopee | 1645 Windemere Way | Shakopee, MN | 55379 | |

| License/Permit # | Permit Holder | Purpose of Inspection | Est Type | Risk Category |
|---|---|---|---|---|
| N010924 | | Full | | |

## FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

## GOOD RETAIL PRACTICES

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

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

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

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

**Food Recalls:**

**Person in Charge (Signature)** **Date:** 01/09/24

Inspector (Signature) Peggy Spudy