Electronically Delivered

May 22, 2026

Licensee
Suite Living Senior Care Of Anoka LLC
525 Cutter Street
Anoka, MN 55303

RE: Project Number(s) SL36849017

Dear Licensee:

On April 30, 2026, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on February 11, 2026. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

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Electronically Delivered

March 11, 2026

Licensee
Suite Living Senior Care of Anoka LLC
525 Cutter Street
Anoka, MN 55303

RE: Project Number(s) SL36849017

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 11, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

pursuant to this survey:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $1,000.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $2,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you

may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,

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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36849	A. BUILDING: _____ B. WING _____	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SENIOR CARE OF ANOKA LLC	525 CUTTER STREET ANOKA, MN 55303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34869017-0 On February 9, 2026, through February 11, 2026, the Minnesota Department of Health conducted a change of ownership (CHOW) survey at the above provider. At the time of the survey, there were 23 resident(s); 23 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.	
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services	0 485		

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0 485	Continued From page 1 (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living contract. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect 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 the entrance conference on February 9, 2026, at 10:21 a.m., licensed assisted living	0 485		

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0 485	Continued From page 2 director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. On February 9, 2026, at 10:27 a.m., LALD-A stated the licensee provided three meals per day and the residents received a monthly credit of $250 if the meal package was declined. The licensee's Memory Care All Inclusive Rates and Assisted Living All Inclusive Rates forms indicated a $250 deduction would be made each month if the resident/family opted out of the meal plan. The forms were provided to every resident at the time of admission. Resident assisted living contracts and services lacked an option for residents to opt out of payment for one, two, or three meals residents would not want. On February 9, 2026, at 2:43 p.m., LALD-A stated LALD-A was aware of the statute requirement which gave residents the opportunity to opt out of one, two, or three meals. LALD-A further stated [licensee] did not have an option for residents to purchase a la carte meals and the meal plan design options were created at the corporate level due to preparation needs from the catering company. The Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQs) website, last updated July 1, 2025, indicated the provider cannot have a blanket "one size fits all" meal charge. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 485		

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0 485	Continued From page 3 (21) days	0 485		
0 775 SS=I	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm? to the resident) 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated February 9, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment	0 790		

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0 790	Continued From page 4 (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated February 9, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.	0 790		

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0 790	Continued From page 5 TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure current employee records contained all the required content to include a current background study clearance letter for two of 37 employees (unlicensed personnel (ULP)-G, ULP-H). This had the potential to affect all residents living within the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a widespread scope (when problems	01290		

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01290	Continued From page 6 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: This resulted in an immediate correction order on February 10, 2026. During the entrance conference on February 9, 2026, at 10:45 a.m., licensed assisted living director (LALD)-A stated the licensee was aware of required contents in an employee record. ULP-G ULP-G was hired January 23, 2026, to provide direct care services to residents residing at [licensee]. The licensee's weekly schedule dated February 9, 2026, through February 15, 2026, indicated ULP-G was scheduled to work from 2:00 p.m. until 10:00 p.m., on February 9, 12, 13, 14, and 15, 2026. On February 9, 2026, at 4:42 p.m., the surveyor observed ULP-G administer scheduled insulin and oral medication to R3. ULP-H ULP-H was hired January 23, 2026, to provide direct care services to residents residing at [licensee]. The licensee's weekly schedule dated February 9, 2026, through February 15, 2026, indicated ULP-H was scheduled to work from 2:00 p.m. until 10:00 p.m., on February 9, 11, 14, and 15, 2026.	01290		

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01290	Continued From page 7 ULP-G and ULP-H's employee records lacked a current cleared background study listed on the licensee's NETStudy 2.0 Roster. On February 10, 2026, at 1:07 p.m., the surveyor reviewed the licensee's NetStudy 2.0 Roster (online background check website) with LALD-A. LALD-A stated the licensee's assistant housing director (AHD) or LALD-A were responsible for completing all employee background studies when hired by the licensee. LALD-A searched ULP-G and ULP-H's name, date of birth, and social security number (SSN) on NETStudy 2.0 website however, the results for both searches read, "your entity is no longer affiliated with this person and you can no longer view this person's profile. You may continue to view prior background study documents for this person on the recent documents screen." LALD-A further stated ULP-G and ULP-H background studies had been initiated however, assumed their fingerprints were not taken thus, the study closed. LALD-A acknowledged that ULP-G and ULP-H worked independently on February 9, 2026, and additional shifts were scheduled for both employees the remainder of the week however, they would be removed until a background study was completed. The licensee's 4.02 Background Studies policy dated August 1, 2021, indicated no employee was allowed to provide direct services and have independent direct contact with any residents until acceptable result of the background study was received. Continuous Direct Supervision defined in NETStudy 2.0 System User Manual Updated July 7, 2023, page 7: Continuous, Direct Supervision - An individual is within sight or hearing of the	01290		

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01290	Continued From page 8 program's supervising individual to the extent that the program's supervising individual is capable at all times of intervening to protect the health and safety of the persons served by the program. Direct Contact Services - Providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the entity. Continuous Direct Supervision defined in NETStudy 2.0 System User Manual Updated July 7, 2023, page 7: Continuous, Direct Supervision - An individual is within sight or hearing of the program's supervising individual to the extent that the program's supervising individual is capable at all times of intervening to protect the health and safety of the persons served by the program. Direct Contact Services - Providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the entity. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
01540 SS=D	144G.64 (a) (3) Training in Dementia, Mental Illness, and De- (3) for assisted living facilities with dementia care, direct-care staff must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, the staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and two hours of training on topics related to mental	01540		

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01540	Continued From page 9 illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-F) received the required amount of mental illness and de-escalation training within the required time frame. 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: The licensee held an assisted living facility with dementia care (ALFDC) license effective March 1, 2025, with an expiration date of February 28, 2026.	01540		

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01540	Continued From page 10 During the entrance conference on February 9, 2026, at 10:45 a.m., licensed assisted living director (LALD)-A stated the licensee was aware of required contents in an employee record. ULP-F was hired on October 1, 2025, to provide direct care services to residents. On February 9, 2026, at 2:27 p.m., the surveyor observed ULP-F and ULP-I complete narcotic medication count verification at change of shift. On February 10, 2026, at 8:33 a.m., the surveyor observed ULP-F administer scheduled morning medications to R9. The surveyor observed licensee's schedule dated February 9, 2026, through February 15, 2026, which indicated ULP-F was scheduled to work Monday through Thursday 6:00 a.m. through 2:00 p.m., daily. ULP-F's employee record included ULP-F's Educare (online education platform) transcript. The transcript indicated ULP-F had completed 0.75 hours of mental illness education, however, ULP-F's employee record lacked evidence of ULP-F having completed the required two hours of mental illness and de-escalation education. On February 11, 2026, at 12:42 p.m., ULP-F stated ULP-F worked full-time for [licensee] and had not changed ULP-F's employment status since being hired. On February 11, 2026, at 12:47 p.m., LALD-A stated all employees had two hours of mental health and de-escalation training issued when hired. LALD-A further stated ULP-F is employed full-time and only completed one of the courses	01540		

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SUITE LIVING SENIOR CARE OF ANOKA LLC	525 CUTTER STREET ANOKA, MN 55303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01540	Continued From page 11 issued and the other two were reissued. The licensee's 4.05 Employee Records policy dated July 20, 2021, indicated employee records contained documentation of all training and in-service education required. The licensee's 5.03 Dementia Training policy dated July 20, 2021, did not address the two-hour mental health or de-escalation training requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01810 SS=D	144G.71 Subd. 12 Medications; over-the-counter drugs; dietary An assisted living facility providing medication management services for over-the-counter drugs or dietary supplements must retain those items in the original labeled container with directions for use prior to setting up for immediate or later administration. The facility must verify that the medications are up to date and stored as appropriate. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure over the counter (OTC) drugs were labeled with directions for use prior to setting up for immediate or later administration for one of one resident (R8) observed during medication administration. This practice resulted in a level two violation (a	01810		

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01810	Continued From page 12 violation that did not harm a client'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: During the entrance conference on February 9, 2026, at 10:27 a.m., clinical nurse supervisor (CNS)- B stated the licensee provided medication management services to residents at the facility. R8's diagnoses included dementia, unspecified psychosis (mental health condition), and endothelial corneal dystrophy (progressive eye disease causing edema and vision loss). R8's Suite Living Service Agreement dated October 1, 2025, indicated R8 received services which included dressing and grooming, meals, medication management, laundry, and housekeeping. On February 10, 2026, at 9:38 a.m., the surveyor observed unlicensed personnel (ULP)-K prepare and administer scheduled medications to R8. During medication administration, surveyor observed on R8's bedside desk, nine bottles of over the counter (OTC) supplements and medications including: - silver crystalline nano, partial bottle remained, expired 2023; - calcium citrate 1200 milligrams (mg), partial bottle remained, no expiration date on bottle; - Xlear nasal spray with xylitol, partial bottle remained, no expiration date on bottle;	01810		

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01810	Continued From page 13 - Xlear nasal spray with xylitol, partial bottle remained, expired March 2024; - Xlear nasal spray with xylitol, partial bottle remained, expires July 2028; - organic liquid probiotic, partial bottle, expires December 2026; - melatonin three mg, partial bottle remained, expired November 2025; - Sambucol black elderberry syrup, sealed bottle, expires May 2028; and - Mineral Ice therapeutic gel, partial container remained, expires February 2026. Each of the OTC bottles lacked a resident label, directions for use, and were not included on R8's eMAR (electronic medication administration record). On February 10, 2026, at 9:50 a.m., ULP-E stated ULP-E had observed the OTC items in R8's room before however, ULP-E believed them to be essential oils thus, ULP-E did not report them to the nurse. On February 10, 2026, at 9:58 a.m., clinical nurse supervisor (CNS)-B stated the facility required a provider order which included medication dose and instructions for all OTC medications and supplements. CNS-B further stated staff were trained to look for OTC medications in residents' rooms and report them to the nurse immediately. CNS-B also stated R8 did not have current provider orders for any OTC medications or supplements and lacked a nursing assessment for self-administration of medications. The licensee's 7.12 Medications - Prescribed, Not Prescribed & OTC policy dated July 2021, indicated the licensee providing medication management services for over-the-counter drugs or dietary supplements must retain those items in	01810		

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01810	Continued From page 14 the original labeled container with directions for use prior to setting up for immediate or later administration. The policy further indicated the licensee must verify the OTC medications were up to date and stored as appropriate. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01810		
01870 SS=D	144G.71 Subd. 18 Medications provided by resident or family me When the assisted living facility is aware of any medications or dietary supplements that are being used by the resident and are not included in the assessment for medication management services, the staff must advise the registered nurse and document that in the resident record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure residents were assessed for self-administration of medications for one of one resident (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:	01870		

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01870	Continued From page 15 During the entrance conference on February 9, 2026, at 10:27 a.m., clinical nurse supervisor (CNS)- B stated the licensee provided medication management services to residents at the facility. On February 9, 2026, at 4:42 p.m., the surveyor observed unlicensed personnel (ULP)-G monitor R3's glucose and administer scheduled medication and insulin. R3 was admitted to the licensee and began receiving assisted living services on October 1, 2025. R3's diagnoses included diabetes, hypertension (elevated blood pressure), heart disease, and osteoarthritis. R3's Suite Living Service Agreement dated September 30, 2025, indicated R3 received assistance with dressing, grooming, meals, medication management, diabetic management, housekeeping, and laundry. R3's Individualized Medication Management Plan dated September 30, 2025, indicated medication administration was provided by facility staff. The plan lacked checking the box which indicated R3 was partially able to self-administer medications. R3's provider orders dated October 8, 2025, included: -Preparation H External Cream 1%, apply to rectum topically as needed for hemorrhoids twice daily after BM (bowel movement)- OK (sic) to self-administer and keep in apt (apartment). R3's Schedule for Feb (February) 2026 (electronic medication administration record	01870		

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01870	Continued From page 16 (eMAR)) dated February 1, 2026, through February 28, 2026, read, "Preparation H External Cream 1%, apply to rectum topically as needed for hemorrhoids- ok for self-administration and keep in apt (apartment) unsupervised self-administration twice daily after BM (bowel movement) - start date October 8, 2025." On February 11, 2026, at 3:06 p.m., clinical nurse supervisor (CNS)-B stated all residents require an assessment be completed by a registered nurse (RN) prior to starting self-administration of any medication. R3's medication management assessment was not updated to reflect R3's new medication order on October 8, 2026. The licensee's 7.03 Medication Management Individualized Plan policy dated July 2021, indicated the licensee prepared and included in the service plan a written statement of the medication management services that were provided to the resident. The policy further indicated resident's medication management plans were current and updated when there were any changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01870		
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.	01880		

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01880	Continued From page 17 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were secured and permitted access to only authorized personnel for one of one two medication carts. This had the potential to affect all residents in assisted living receiving medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on February 9, 2026, at 10:27 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. On February 10, 2026, during continuous observation from 3:52 p.m. until 4:09 p.m., the surveyor observed assisted living medication cart to be unsecured and unattended by licensee staff. During continuous observation, unlicensed personnel (ULP)-M walked past the medication cart and surveyor to answer a resident's call light and did not notice the medication cart was unlocked or acknowledge the surveyor standing next to the medication cart. At 4:09 p.m., ULP-I exited the laundry room and walked to surveyor standing at the medication cart. ULP-I was asked if ULP-I was assigned to the medication cart and	01880		

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01880	Continued From page 18 held the medication cart keys. ULP-I looked to the medication cart and responded 'yes' to the surveyor's questions, proceeded to lock the medication cart, and stated, "[ULP-I] thought [ULP-I] had locked it." On February 11, 2026, at 4:11 p.m., clinical nurse supervisor (CNS)-B stated ULPs were trained to lock the medication cart anytime they were going to lose eyesight of the cart. CNS-B further stated all staff were expected to assure the medication cart was locked if unattended, even when not assigned to pass medications. On February 12, 2026, at 9:38 a.m., CNS-B stated nursing leadership created a Kahoot (online game and quiz platform) which addressed what staff were to do with the medication cart prior to walking away. CNS-B further stated each ULP completed the Kahoot quiz on the first day of medication training. The licensee's 7.11 Medication Storage policy dated July 2021, indicated medications managed outside of a resident's private "living space" (sic) must be secured in a locked and substantially constructed compartment and permit only authorized personnel to have access. This may be a medication room, medication cart, or similar setup. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for	01890		

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01890	Continued From page 19 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 medications were maintained bearing the original prescription label with legible information including the open and expiration dates for time sensitive medications for one of two medication carts (assisted living, memory care). In addition, the licensee failed to monitor for expired medication in one of one overflow medication storage cabinet and one of two medication carts. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on February 9, 2026, at 10:27 a.m., clinical nurse supervisor (CNS)- B stated the licensee provided medication management services to residents at the facility. TIME SENSITIVE MEDICATION On February 9, 2026, at 4:42 p.m., the surveyor observed the assisted living medication cart with	01890		

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01890	Continued From page 20 unlicensed personnel (ULP)-G and observed R3's open insulin aspart 100 units/milliliter (U/mL) insulin pen. R3's insulin aspart pen was not labeled with an open date or expiration date. ULP-G stated ULP-G was trained to write the open and expiration dates on the insulin pen when it was removed from the medication refrigerator. EXPIRED MEDICATION On February 9, 2026, at 11:38 a.m., the surveyor observed secured overflow medication storage with registered nurse (RN)-C and observed the following expired medication: - R5's gas relief extra strength (ES) 125 milligrams (mg), quantity 29 chewable tablets, expired October 24, 2025. On February 9, 2026, at 2:33 p.m., the surveyor observed memory care medication cart with ULP-I and observed the following expired medication: - R6's Centrum Women vitamin, partial bottle, expired December 2025. On February 9, 2026, at 11:43 a.m., RN-C stated medication supplies were audited weekly by nursing staff and expired medication was missed in error. On February 9, 2026, at 11:49 a.m., clinical nurse supervisor (CNS)-B stated medication supplies are audited weekly for expiration dates and labeled and [CNS-B] missed those. On February 9, 2026, at 5:03 p.m., CNS-B stated ULPs were trained to label time sensitive medications, including insulin pens, with an open date and expiration date. R3's insulin pen lacked required dates and was missed until ULP-G noted	01890		

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01890	Continued From page 21 the missing information while ULP-G performed rights of administration today. The manufacturer's instructions for use of insulin injection dated October 2021, indicated insulin aspart single-patient-use (sic) insulin pens were safe to use for 28 days after being opened. The licensee's 7.11 Medication Storage policy dated July 2021, indicated medications were stored consistently with manufacturer's recommendations (refrigerated, room temperature, or frozen). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02320 SS=E	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the steps of the medication administration process were followed for two of four employees (unlicensed personnel (ULP)-J and ULP-K). This practice resulted in a level two violation (a	02320		

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02320	Continued From page 22 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). During the entrance conference on February 9, 2026, at 10:27 a.m., clinical nurse supervisor (CNS)- B stated the licensee provided medication management services to residents at the facility. On February 10, 2026, at 9:38 a.m., the surveyor observed ULP-K provide scheduled medication to R8. ULP-K dispensed oral medications into a medication cup then stated R8's nystatin (antifungal) powder and barrier cream were not in the medication cart due to ULP-J obtaining them prior to assisting R8 with morning ADLs (activities of daily living) at which time the medications would be applied as directed. ULP-K proceeded to R8's room and administered R8's scheduled oral medications to R8. Prior to exiting R8's room, ULP-K located the prescribed barrier cream in R8's bathroom and stated the prescribed nystatin powder was not located. ULP-K returned the barrier cream to the medication cart and proceeded to document administration completed for the scheduled oral medications. ULP-K further documented administration of the barrier cream and medication not available for the nystatin powder. ULP-J ULP-J was hired on October 1, 2025, to provide direct care services to residents.	02320		

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02320	Continued From page 23 ULP-K ULP-K was hired on December 12, 2025, to provide direct care services to residents. ULP-K's employee record contained Medication Administration- Routes competency document, undated, and signed by registered nurse (RN)-L. Page two of the competency document indicated RN-L marked ULP-K as having passed the ability to safely and correctly administer topical medications of which step 12 was to document administration. On February 10, 2026, at 9:49 a.m., ULP-K stated ULP-K documented the barrier cream as administered and the nystatin powder as unavailable because it was not found along with the barrier cream in R8's bathroom. ULP-K further stated ULP-K documented the medications which were administered by ULP-J because ULP-K was scheduled to pass medications and was already in R8's eMAR (electronic medication administration record). On February 11, 2025, at 9:53 a.m., clinical nurse supervisor (CNS)-B stated licensee staff were trained to only document medication(s) administered by oneself and not to document medications administered by someone else. CNS-B further stated that in R8's situation, the ULP who administered R8's barrier cream and nystatin powder was supposed to have completed documentation on R8's eMAR for those medications, not the ULP who was assigned as the med passer. On February 11, 2026, at 12:49 p.m., ULP-J stated ULP-J obtained R8's barrier cream and nystatin powder from the medication cart to apply to R8 when ULP-J assisted with R8's morning	02320		

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02320	Continued From page 24 ADLs. ULP-J further stated whomever is assigned to administer medications would chart the administration of barrier cream and nystatin powder when charting for R8's oral medications was completed. The licensee's 7.15 Medication & Treatment-Administration & Delegation policy dated July 2021, indicated a RN must instruct the med (medication) aide (ULP) on the following medications administration tasks and deem the medication aide competent before delegating the medication administration task to the med aide: -the complete procedure of checking a resident's medication administration record (MAR); -the preparation of medication for administration; -the administration of the medication to the resident; -the reminder to self-administer medications; and -the documentation after assistance with medication reminder or medication administration, of the date, time, dosage, and method of administration of all medications, or the reason for not assisting with medication administration as ordered, and the initials of the nurse or authorized person who assisted or administered and observed the same [sic]. The policy further indicated the ULP must demonstrate their ability to competently follow the delegated medication administration or treatment to an RN. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

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

Food & Beverage Inspection Report

Establishment Info

Suite Living of Anoka
525 Cutter Street
Anoka, MN 55303
Anoka County
Parcel:

Phone:

License Info

License: HFID 36849

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F7963261030
Inspection Type: Full - Single
Date: 2/10/2026 Time: 1:30 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

Met with housing director Jill Wippler and regional director of operations Vince Beckel along with MDH nursing surveyor Allison Skillingstad. Change of ownership from Personal Care Management to Suite Living Anoka. Foodservice is now run by a third party (Unidine) and is licensed and inspected by Anoka Co.

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

I acknowledge receipt of the Metro District Office inspection report number F7963261030 from 2/10/2026

Jill Wippler
Housing Director

Peggy Spadafore,
Public Health Sanitarian Supervisor
651-201-3979
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Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL36849017	**Date:** 2/9/2026
Facility Name: Suite Living Senior Care of Anoka	
Facility Address: 525 Cutter St., Anoka, Minnesota 55303	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 3; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. Access doors for automatic sprinkler system riser rooms and fire pump rooms shall be labeled with an approved sign. The lettering shall be in contrasting color to the background. Letters shall have a minimum height of 2 inches (51 mm) with a minimum stroke of $^{3}/_{8}$ inch (10 mm). [Minn. Stat. 144G.45 subd. 2; MSFC 901.4.6.2]

   Comments: A closet containing a water softener near the front lobby of the facility had signage labelling it as a sprinkler riser room despite not containing any equipment related to the fire suppression system or sprinklers. Facility staff indicated that the room was mislabeled. The incorrect signage should be removed to avoid confusion and misdirecting firefighting personnel during an emergency. The actual riser room should have proper signage maintained.

3. Controlled egress locking systems shall: unlock upon activation of either the automatic sprinkler system or automatic fire detection system, unlock upon loss of power controlling the lock, have the capability of being unlocked from the fire command center, a nursing station, or other approved location. Building occupants shall not be required to pass through more than one controlled egress locked door before entering an exit. The procedures for operation of the unlocking system shall be described as part of the fire safety and evacuation plan. All clinical staff shall have the keys, codes, or other means necessary to operate the locking device. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9.7]

   Comments:

The memory care wing of the facility had controlled egress doors limiting the ability to exit from that area. There was no method to release the controlled egress doors via remote release button or switch from the locked controlled egress area of the memory care wing of the facility.

The exit signs installed in the memory care wing of the facility designated a path of egress that would require an occupant to pass through two sets of controlled egress doors. Exit signs indicated a path of egress through a controlled egress door leading to the front dining seating area, and then through the controlled egress door leading to the front vestibule. The path of egress may not require passing through more than controlled egress door.

4. Fire detection and alarm systems, emergency alarm systems, gas detection systems, fire-extinguishing systems, mechanical smoke exhaust systems and smoke and heat vents shall be maintained in an operative condition at all times and shall be replaced or repaired where defective. [Minn. Stat. 144G.45 subd. 2; MSFC 901.6]

   Comments: There was a non-compliance tag dated 8/8/2025 on the kitchen Ansul suppression system indicating that issues with the system. The tag indicated issues with the wiring of the Ansul system and that the system was not properly functional. The Ansul system should be brought back to proper state of repair and maintained in working order. The conduit wiring for the Ansul system in the fire panel room was not properly connected and was hanging loose from the junction box. Wiring should be repaired, and the system should be maintained in proper condition.

5. Fire department connections shall be periodically inspected, tested and maintained in accordance with NFPA 25. Records of inspection, testing and maintenance shall be maintained. [Minn. Stat. 144G.45 subd. 2; MSFC 901.6.1; MSFC 912.7; NFPA 25(11), Sec. 5.2.1.4; NFPA 25(11), Sec. 5.4.1.6.5]

   Comments: The provided sprinkler head box in the fire panel room did not contain any sprinkler wrenches for the replacement of sprinkler heads. The supplied cabinet should be maintained with all required spare sprinkler heads, wrenches, and any other required materials.

6. Lighted matches, cigarettes, cigars or other burning object shall not be discarded in such a manner that could cause ignition of other combustible material. [Minn. Stat. 144G.45 subd. 2; MSFC 310.7]

   Comments: A significant number of discarded cigarette butts were laying on the ground on either side of the front entry to the facility. The cigarettes were lying in the grass and were not properly disposed of, presenting risk of fire. All smoking materials should be properly disposed of in approved receptacles.

☒ **TAG IDENTIFICATION: 0790**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

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1. Portable fire extinguishers installed and maintained to MN State Fire Code. [Minn. Stat. 144G.45 subd.2]

   Comments:

   Several fire extinguishers provided throughout the facility did not indicate record of proper monthly staff inspection. The extinguishers provided at the assisted living nursing station, in the kitchen, and in the kitchen riser room were missing adequate monthly inspection records. Extinguishers should have visual inspections conducted and recorded monthly by staff.

   The fire extinguisher located in the memory care electrical closet did not have a current annual service tag. The extinguisher in this closet had a service tag indicated service in January 2021 and no further servicing records were provided. Extinguishers should be serviced annually by licensed contractor.