Electronically Delivered

January 21, 2026

Licensee
Suite Living Senior Care of Brooklyn Park
8500 Regent Avenue North
Brooklyn Park, MN 55443

RE: Project Number(s) SL36600016

Dear Licensee:

On December 17, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on November 7, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the November 7, 2025 survey.

The Department of Health concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on November 7, 2025, found not corrected at the time of the December 17, 2025, follow-up survey and/or subject to penalty assessment are as follows:

2310-Appropriate Care And Services-144g.91 Subd. 4 (a)

The details of the violations noted at the time of this follow-up survey completed on December 17, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

DOCUMENTATION OF ACTION TO COMPLY

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

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

We urge you to review these orders carefully. If you have questions, please contact Jess Schoenecker at 651-201-3789.

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.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 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
	36600	A. BUILDING: _____ B. WING _____	R 12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SR CARE OF BP	8500 REGENT AVENUE NORTH BROOKLYN PARK, MN 55443

(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL36600016-1 On December 16, 2025, through December 17, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed November 7, 2025. At the time of the survey, there were 27 residents; 27 receiving services under the Assisted Living Facility with Dementia Care license. As a result of the follow-up survey, the following order was reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 510} SS=E	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	{0 510}		

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{0 510}	Continued From page 1 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	{0 510}	Not reviewed during this survey.	
{0 775} SS=F	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:	{0 775}	Not reviewed during this survey.	
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for	{0 810}		

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{0 810}	Continued From page 2 residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}	Not reviewed during this survey.	
{01420} SS=F	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to	{01420}		

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{01420}	Continued From page 3 demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by:	{01420}	Not reviewed during this survey.	
{01620} SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation	{01620}		

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{01620}	Continued From page 4 of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by:	{01620}	Not reviewed during this survey.	
{01760} SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who	{01760}		

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{01760}	Continued From page 5 administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by:	{01760}		
{01940} SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and	{01940}	Not reviewed during this survey.	

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{01940}	Continued From page 6 (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by:	{01940}	Not reviewed during this survey.	
{02310} SS=D	144G.91 Subd. 4 (a) Appropriate care and services (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. This MN Requirement is not met as evidenced by: Based on 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 four residents (R5) who utilized bed rails. 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	{02310}		

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{02310}	Continued From page 7 situation has occurred only occasionally). The findings include: R5 was admitted for services on July 21, 2025, and had diagnoses including hemiplegia and hemiparesis (damage to one side of the brain, causing weakness/paralysis on one side of the body, impacting movement, balance, and daily tasks), type 2 diabetes, history of falls, chronic pain, and epilepsy (seizures). R5's record included a Bed Rail Assessment completed on July 21, 2025, and December 16, 2025, at 3:34p.m., after the survey was initiated. R5's record In Progress Bedrail Assessment emailed to R5's representative by regional director of nursing (RDN)-A. On December 16, 2025, at 4:30 p.m. RDN-A verified "In Progress Bedrail Assessment" was request family to e-sign the risks versus benefits with the use of bed rails. R5's record lacked documentation that the registered nurse (RN) educated R5 and/or R5's representative on the risks versus benefits with the use of bed rails and ongoin bedrail reassessment was performed before the follow up survey was initiated. On December 17, 2025, at 11:30 a.m. RDN-A acknowledged R5's bed rail reassessment and education to resident and resident's representative on the risks versus benefits with the use of bed rails was not completed before the survey was initiated. Also, RDN-A stated "In looking at our system, when completing a bed rail assessment, it does not automatically set up a	{02310}		

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{02310}	Continued From page 8 reminder to reassess every 90 days. We have been looking into how to change this process to ensure reminders are given to nursing to complete the assessments timely." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) last updated April 3, 2024, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include	{02310}		

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{02310}	Continued From page 9 in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. The Food and Drug Administration (FDA) "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The licensee's 6.28 Side rails policy dated May 10, 2025, indicated "When [licensee] is aware a resident is utilizing side rails on a bed, [licensee] will assess the use, educate the resident, and when appropriate, the resident representative, regarding the risk and benefits of side rails, and verify the side rail in use is of a safe design and utilized with the manufacturer's guidelines. This policy shall be followed regardless of who owns or is supplying the side rail." No further information was provided.	{02310}		

Electronically Delivered

November 24, 2025

Licensee
Suite Living Senior Care of Brooklyn Park
8500 Regent Avenue North
Brooklyn Park, MN 55443

RE: Project Number(s) SL36600016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 7, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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 - $500.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

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SUITE LIVING SR CARE OF BP	8500 REGENT AVENUE NORTH BROOKLYN PARK, MN 55443

(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: SL36600016-0 On November 3, 2025, through November 7, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 28 residents; 28 receiving services under the Assisted Living Facility with Dementia Care license. On November 6, 2025, an immediate correction order was issued for tag identification 2310. During the course of the survey, the licensee took action to mitigate the immediate risk. Noncompliance remained and the scope and level remain unchanged. After the completion of the survey, identifier R8 in tag 2310 was later changed to R6.	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.	

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0 510	Continued From page 1	0 510		
0 510 SS=E	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical, and nursing standards for infection control related to hand hygiene for two of two employees (unlicensed personnel (ULP)-B, ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include:	0 510		

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0 510	Continued From page 2 ULP-B and ULP-F were hired on August 29, 2023, and March 12, 2025, respectively, to provide assisted living services. ULP-B On November 4, 2025, at 9:00 a.m., ULP-B was in the middle of setting up medications for an unknown resident when the surveyor approached the medication cart. ULP-B administered those medications to the unknown resident then proceeded back to the medication cart and began setting up R6's medication without performing hand hygiene (HH) by either washing hands or using hand sanitizer. ULP-B administered R6's medications within R6's room. ULP-B went back to the medication cart and began setting up R3's medications without performing HH. After setting up the oral medications, ULP-B set up the insulin pen and brought the medications to R3's room where she applied gloves then made R3's bed then administered an eye drop to both eyes and took R3's blood pressure. R3 took his oral medications, checked the blood glucose by poking a finger with a needle to draw blood for the glucometer then ULP-B injected insulin into R3's abdomen. ULP-B then went to the medication cart to place the needle into a sharps container then removed gloves, put items back into the medication cart and documented on the computer. Without performing HH, ULP-B then began setting up R4's medication. Once R4's oral medications were set up, ULP-B set up two insulin pens, went to R4's room where R4 was lying in bed. After R4 took her oral medication, ULP-B applied gloves, checked the blood glucose by poking a finger with a needle to draw blood for the glucometer then injected one insulin in the abdomen. The second insulin did not have	0 510		

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0 510	Continued From page 3 enough insulin, so ULP-B removed gloves and went to the nursing office to grab a new insulin pen, then applied new gloves without performing HH, and administered the insulin into R4's back of arm. ULP-B then removed gloves and logged into the computer to document the administration without performing HH. ULP-B set up R5's medication, went to R5's room, took her blood pressure, administered the medication, then came back to the medication cart to finish documentation. No HH was performed and ULP-B stated she was completed with medication administration. ULP-B administered medications to four residents, checked blood glucose twice, and administered insulin to two people and did not perform any HH during that period of time. ULP-B's OSHA (Occupational Safety and Health Administration) & Infection Control competency dated September 15, 2023, indicated ULP-B was competent to perform handwashing and using alcohol-based rub (hand sanitizer). ULP-F On November 4, 2025, at 11:11 a.m., ULP-F set up R8's medications, administered them to R8, then came back to the medication cart to complete documentation without performing HH. ULP-F then proceeded to set up R10's medications and administered them to him and came back to the medication cart to complete documentation without performing HH. ULP-F then set up one medication for R12, administered it, then documented without performing HH. ULP-F then set up R11's medication, administered the medication, and documented without performing HH. ULP-F then set up R7's medication, checked blood pressure, went back	0 510		

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0 510	Continued From page 4 to medication cart to document without performing HH. ULP-F begun setting up R6's medication but the surveyor did not observe the completion of that medication pass. ULP-F did not perform any HH in between six residents. ULP-F's OSHA & Infection Control competency dated March 17, 2025, indicated ULP-B was competent to perform handwashing and using alcohol-based rub (hand sanitizer). During interview on November 4, 2025, at 2:45 p.m., regional director of nursing (RDN)-A stated staff were supposed to be performing HH before and after each medication pass. The Centers for Disease Control (CDC) Clinical Safety: Hand Hygiene for Healthcare Workers dated February 27, 2024, recommended to clean your hands: - immediately before touching a patient; - before performing an aseptic task such as placing and indwelling device or handling invasive medical devices; - before moving from work on a soiled body site to a clean body site on the same patient; - after touching a patient or patient's surroundings; - after contact with blood, body fluids, or contaminated surfaces; and - immediately after glove removal. The licensee's 8.07 Gloves policy dated July 20, 2021, indicated staff were to wash hands before applying gloves and after removing gloves. The licensee's 8.09 Hand Washing policy dated July 20, 2021, indicated proper hand washing techniques should be used to protect the spread	0 510		

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0 510	Continued From page 5 of infection. When conducting a procedure requiring the use of gloves, proper hand hygiene should be completed before applying gloves and after removing gloves. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 775 SS=F	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 and interview, the licensee failed to comply with Minnesota State Fire Code in Minnesota Rules chapter 7511. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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: On November 4, 2025, at approximately 10:00 a.m., the surveyor toured the facility with regional	0 775		

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0 775	Continued From page 6 director of operations (RDO)-E and housing director (HD)-C. The following was observed: The facility is equipped with controlled egress locks on the memory care wing and also on the door at the main entrance of the building before entering the exit in the enclosed vestibule. As a result, occupants shall pass through two locked controlled egress doors and an exit door before accessing the exterior. Building occupants shall not be required to pass through more than one door equipped with a controlled egress lock before entering an exit. On November 4, 2025, HD-C stated they are aware of the requirement and is discussing this issue with others at this time. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 775		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive	0 810		

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0 810	Continued From page 7 training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). On November 4, 2025, housing director (HD)-C provided documents on the fire safety and	0 810		

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0 810	Continued From page 8 evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log, no drills were conducted with the overnight staff. No other documentation was provided. On November 4, 2025, HD-C stated there were no additional documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01420 SS=F	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record.	01420		

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01420	Continued From page 9 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) ensured training and competency demonstrations were completed for three of three employees (unlicensed personnel (ULP)-B, ULP-F, ULP-G) for the use of a Broda chair (oversized cushioned wheelchair). 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 observation on November 3, 2025, at 2:57 p.m., ULP-G and ULP-L assist R2 transfer from bed to a Broda chair using a mechanical full body lift with sling. During observations on November 4, 2025, at 10:45 a.m., the surveyor observed within a secured memory care unit three (3) residents (R8, R9, third person was unknown) sitting in Broda chairs next to each other in the common area. At 11:11 a.m., ULP-F set up R8's medication, crushed the medication, placed them into pudding, then proceeded to R8. R8 was reclined in the Broda chair, so ULP-F raised the back of her chair by squeezing the handle and lifting up so R8 could take her medications.	01420		

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01420	Continued From page 10 ULP-B, ULP-F, and ULP-G were hired on August 29, 2023, March 12, 2025, and June 11, 2024, respectively, to provide assisted living services. The licensee's staff schedule dated November 3-9, 2025, indicated ULP-B was scheduled to work 6:00 a.m. through 2:00 p.m. on November 3-6, 2025, as the medication passer or caregiver for the assisted living residents. ULP-F was scheduled to work 6:00 a.m. through 2:00 p.m. on November 3, 4, 5, 8, and 9, 2025, as the medication passer or caregiver for the memory care residents. ULP-G was scheduled to work 2:00 p.m. through 10:00 p.m. on November 3, 4, 6, and 7, 2025, as a medication passer and caregiver. ULP-B, ULP-F, and ULP-G's employee records lacked training and competency evaluation on use of Broda chairs. During phone interview on November 6, 2025, at 12:32 p.m., registered nurse corporate educator (RNCE)-J stated Broda chair training and evaluation was added to her training program as of two weeks ago. RNCE-J stated facility nurses were responsible for completing the training up until then. On November 7, 2025, at 8:33 a.m., the surveyor sent an email to regional director of nursing (RDN)-A, asking if ULP-B, ULP-F, and ULP-G received training on Broda chair use. On November 7, 2025, at 8:39 a.m., the surveyor received an e-mail from RDN-A which indicated ULP-B, ULP-F, and ULP-G did not receive training. RDN-A stated the licensee had a staff meeting scheduled for November 19 and would	01420		

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01420	Continued From page 11 complete Broda chair competency at that time to ensure all staff members were competent in that task. On November 7, 2025, at 2:33 p.m., the surveyor received an e-mail from housing director (HD)-C with completed Broda chair competencies for ULP-B, ULP-F, and ULP-G signed by RNCE-J on November 7, 2025. The licensee's 5.02 Competency Training Evaluations policy revised December 21, 2022, indicated prior to the delegation of services, they must make certain the ULP is trained in the proper methods to perform the tasks or procedures for each resident and are able to demonstrate the ability to competently follow the procedures and perform the tasks. A copy of all education, training, and competency testing shall be kept in each employee's personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01420		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in,	01620		

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01620	Continued From page 12 whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.	01620		

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01620	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a change in condition assessment to include current and accurate transfer needs for one of one resident (R7). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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: R7 was admitted for services on October 15, 2024, and had diagnoses including bipolar disorder (extreme mood swings from depression to mania), vascular dementia (decrease in blood flow to brain causing cognitive impairment and memory loss), repeated falls, and history of stroke. During observation on November 4, 2025, at 11:40 a.m., unlicensed personnel (ULP)-F met R7 in the common area where she was sitting in her manual wheelchair watching television. ULP-F took R7's blood pressure prior to administering medication. R7 was escorted to the dining room table and provided lunch that consisted of mechanical soft foods (diced up Philly cheesesteak without bun, chopped up	01620		

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	36600	A. BUILDING: _____ B. WING _____	11/07/2025

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01620	Continued From page 14 potato wedges, and mandarin oranges). R7's care plan as of November 6, 2025, indicated R7 received assistance with medication administration, bathing, toileting, behavior management, dressing and grooming, wheelchair and walker, safety checks, and two staff using Hoyer lift (full body lift with sling) or R7 could be assist of one depending on needs at the moment. R7's task documentation from November 1-5, 2025, indicated staff had documenting (initialing) they provided "TRANFERRING: Requires assistance 2 staff assistance and Hoyer lift with size appropriate sling to transfer/Resident can also be an assist of one depending on needs at the moment." R7's post-hospital nursing assessment completed by regional director of nursing (RDN)-A on August 27, 2025, assessed R7 required assistance of two staff using a Hoyer lift and assistance of one staff with use of Broda chair (oversized cushioned wheelchair that tilted back and raised legs). The assessment also indicated R7 performed unsafe behavior of self-transfers. R7's change in condition nursing assessment dated September 11, 2025, indicated R7 was discharged from hospice (end of life service) and began physical and occupational therapy home care service. The assessment also assessed R7 required assistance of two staff using a Hoyer but R7 could be assist of one depending on needs at the moment. R7's provider orders dated September 9, 2025, indicated a home occupational therapy	01620		

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01620	Continued From page 15 evaluation was completed that day and received treatment sessions to address activities of daily living and walker safety. R7's incident progress note dated October 12, 2025, at 8:50 a.m., RDN-A noted R7 was walking in her room independently with a walker and while walking out of her room into the hallway, she fell on top of her walker. R7's post-fall follow up progress note (from incident on October 12) dated October 13, 2025, at 11:11 a.m., RN-K noted during post-fall follow up, R7 was able to ambulate with walker. R7's post-fall follow up progress note (from incident on October 12) dated October 14, 2025, at 3:40 p.m., RN-K noted R7 had been walking with walker. R7's record lacked a change of condition assessment following change in physical assistance from using a Hoyer to stand by assist using a walker. During interview on November 7, 2025, at 9:10 a.m., RDN-A stated on September 11, 2025, R7 was discharged from hospice and admitted to homecare therapy and was no longer using the Hoyer lift and instructed staff to assist R7 with pivot transfers. RDN-A stated R7 currently liked to get up and walk around but required either contact guard assist using a gait belt around waist (light hand on resident to assist) or stand by assistance (no touch but nearby to intervene if needed) with walker. RDN-A stated she did not complete the most recent nursing assessment and stated the transfer assistance on the care plan needed to be updated to reflect the current	01620		

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01620	Continued From page 16 needs of R7 and that was an oversight on her part. The licensee's 6.08 Service Plan policy dated August 1, 2022, indicated the service plans are based on the outcomes of initial and subsequent assessments, reassessments, monitoring, and individual reviews of the resident's needs and preferences. Service plans shall be revised, if needed, based on resident reassessments and monitoring. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications	01760		

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01760	Continued From page 17 were administered per prescriber orders for three of nine residents (R3, R5, R7) receiving medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R3 R3 was admitted for services on August 9, 2022, with diagnoses including peripheral vascular disease (reduced blood flow to limbs), major depressive disorder, type two diabetes, hypertension, muscle weakness, and atrial fibrillation (abnormal heart rhythm). During interview with R2 (who lived within an assisted living apartment) indicated breakfast, lunch, and dinner were served at 8:00 a.m., 12:00 p.m., 5:00 p.m. On November 4, 2025, at 9:10 a.m., the surveyor observed unlicensed personnel (ULP)-B set up R3's morning medications including oral medication and Novolog flex pen insulin by placing a needle on the pen, wasting 2 units of insulin (standard practice to ensure accurate dosing), then dialing the pen to 35 units per R3's medication administration record (MAR). ULP-B stated R3 already ate breakfast (liked to eat early in the morning) and preferred to receive his	01760		

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01760	Continued From page 18 insulin after breakfast. ULP-B then entered R3's room and found R3 sitting in his recliner watching television, briefly made his bed, administered eye drops to both eyes, checked R3's blood glucose which was 297, then checked R3's blood pressure (required prior to administering one oral medication). ULP-B gave all oral medications then injected R3's Novolog insulin into his abdomen. R3's [licensee] Service Agreement-V5 dated July 29, 2025, indicated R3 received assistance with vital checks (pulse, respiration, blood pressure, oxygen saturation, weight, and temperature) per provider orders or at least monthly and as needed, bathing, dressing, grooming, toileting, escorts, transfer assistance, safety checks, blood glucose monitoring, and medication administration. R3's prescriber orders signed March 10, 2025, ordered Novolog insulin, inject 35 units subcutaneously three times per day with meals for type two diabetes. R3's MAR dated November 1-5, 2025, instructed staff to inject 35 units of Novolog FlexPen 100 units/1 milliliter (ml) with meals (8:00 a.m., 12:00 p.m., 5:00 p.m.). R3's MAR dated October 1-31, 2025, indicated the following Novolog insulin documentation: -three (3) doses of 8:00 a.m. insulin was administered by ULP-B between 8:33 a.m. and 8:54 a.m.; and -six (6) doses of 8:00 a.m. insulin was administered by ULP-B between 9:07 a.m. and 10:06 a.m.	01760		

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01760	Continued From page 19 During interview on November 4, 2025, at 2:45 p.m., regional director of nursing (RDN)-A stated R3's Novolog was supposed to be given 15 minutes prior to eating a meal and was not aware his blood glucose checks and insulin administration was completed after eating. R5 R5 was admitted for services on July 21, 2025, and had diagnoses including hemiplegia (paralysis) affecting right side following a stroke, type 2 diabetes, history of falls, chronic pain, and epilepsy (seizures). During observation on November 4, 2025, at 9:36 a.m., ULP-B set up the following medications for R5: amlodipine 10 milligram (mg) (one tablet) for high blood pressure (B/P), aspirin 81 mg (one tablet) for heart health, fluoxetine 40 mg (one capsule) for depression, lamotrigine 200 mg (one tablet) for tremors, lisinopril 40 mg (one tablet) for high B/P, metformin 1000 mg (one tablet) for diabetes, and metoprolol 25 mg (instructions on MAR stated hold medication if pulse was less than 60 beats per minute) for high B/P and placed in a small medication cup. ULP-B then went to R5's room and met R5 sitting at her desk using her computer. ULP-B used the automatic blood pressure monitor to R5's left arm and results were 118/56 for B/P and 58 for pulse. ULP-B then gave R5 the medication cup and R5 took all medications including the metoprolol tablet. After leaving R5's room, the surveyor asked why ULP-B gave R5 her metoprolol and ULP-B stated she made a mistake and her process was to separate the metoprolol using another medication cup and if the pulse was outside of parameters to give, she would hold the medication. She forgot to utilize that process, so	01760		

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01760	Continued From page 20 all medications were given. R5's care plan as of November 4, 2025, indicated R5 received assistance with medication and treatment administration. R5's admission orders dated July 12, 2025, ordered metoprolol 50 mg tablet, give 25 mg by mouth two times per day for hypertension, hold for heartrate less than 60. R5's MAR dated October 1-31, 2025, indicated to give one tablet of metoprolol 25 mg twice a day for hypertension, hold if pulse was less than 60. The MAR also indicated metoprolol was held by indicating a number "4" which meant the pulse was outside of parameters for administration or indicating a number "5" meaning the medication was held and reference the progress note eight (8) out of 14 times when the pulse was below 60, and six (6) doses were administered (MAR showed a check mark with staff initials). During interview on November 4, 2025, at 2:45 p.m., RDN-A stated if a resident's pulse was outside of parameters, staff were instructed to contact the nurse prior to holding a medication and get direction from the nurse on whether to hold or give it. R7 R7 was admitted for services on October 15, 2024, and had diagnoses including bipolar disorder (extreme mood swings from depression to mania), vascular dementia (decrease in blood flow to brain causing cognitive impairment and memory loss), repeated falls, and history of stroke.	01760		

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01760	Continued From page 21 During observation on November 4, 2025, at 11:40 a.m., ULP-F met R7 in the common area where she was sitting in her manual wheelchair watching television. ULP-F took R7's B/P using an automatic B/P machine using the left arm, result was 92/33, pulse 79. ULP-F went to the medication cart to set up R7's medication per MAR: -divalproex 500 mg tablet for bipolar disorder, -midodrine 5 mg tablet with meals for B/P, if systolic B/P (SBP-top number) is greater than 90, okay to administer; and -polyethylene glycol 17 grams mixed with fluid for constipation. Just before ULP-F was about to administer R7's medication, the surveyor intervened asking ULP-F to check with RDN-A regarding the low B/P. RDN-A instructed ULP-F to retake the B/P on the same arm then the opposite arm. R7's B/P on the left arm was 83/44 and right arm was 93/58, pulse 81. RDN-A was notified of the results and instructed ULP-F to hold the midodrine medication, offer R7 fluids and recheck B/P later. B/P later was 103/58. R7's care plan as of November 6, 2025, indicated R7 received assistance with medication administration. R7's hospital discharge orders dated August 27, 2025, indicated R7 had recurrent hypotension (low B/P) and was on scheduled midodrine (to help increase a low B/P) 5 mg three times a day (TID) with additional 5 mg TID as needed (PRN) for SBP less than 90. R7's MAR dated October 1-31, 2025, indicated the same instructions as November MAR during observation for administering midodrine. The	01760		

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01760	Continued From page 22 MAR also included the following information: -PRN midodrine 5 mg tablet for SBP less than 90 (correct instructions), give one tablet with scheduled dose. The MAR showed PRN midodrine was not given for the entire month. -the MAR also indicated scheduled midodrine was held five (5) times because SBP was less than 90 by indicating a number "4" which meant the blood pressure was outside of parameters for administration; and -the MAR also indicated seven (7) times R7's SBP was below 90, which R7 should have received the PRN dose in conjunction with scheduled does, which did not occur. During phone interview on November 7, 2025, at 9:10 a.m., RDN-A explained licensed practical nurse (LPN)-I transcribed the scheduled midodrine order incorrectly. RDN-A stated the process for medication review done during 90-day assessments, included reviewing the resident's vital signs and determining if the results were within normal limits, review behavior notes, assess resident face to face, and interview staff to determine any changes. ULP-B's Skill Competency Medication Administration-Routes and Skill Competency Medication & Treatment: Insulin Pens both dated September 15, 2023, signed by registered nurse/corporate educator (RNCE)-J that indicated ULP-B was competent to administer insulin by performing safety checks-right insulin, right person, right dosage, right time. The licensee's 7.15 Medication & Treatment-Administration & Delegation policy dated July 2021, indicated when administration of medications or treatments are delegated to ULP,	01760		

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01760	Continued From page 23 licensee would ensure that the registered nurse has instructed the ULP in proper methods with respect to each resident to administer medications and/or treatment, and the ULP has demonstrated the ability to competently follow the procedures. The licensee's 7.03 Medication Management Individualized Plan policy dated July 2021, indicated the licensee would verify that all medications were administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. The policy also indicated the medication management record would be current and updated when there were any changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy	01940		

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01940	Continued From page 24 administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for 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: R3 was admitted on August 9, 2022, with diagnoses including peripheral vascular disease	01940		

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01940	Continued From page 25 (reduced blood flow to limbs), major depressive disorder, type two diabetes, hypertension, muscle weakness, and atrial fibrillation (abnormal heart rhythm). On November 4, 2025, at 9:10 a.m., the surveyor observed unlicensed personnel (ULP)-B check R3's blood pressure, administer oral medications, and check R3's blood glucose prior to administering insulin by injection. R3's [licensee] Service Agreement-V5 dated July 29, 2025, indicated R3 received assistance with vital checks (pulse, respiration, blood pressure, oxygen saturation, weight, and temperature) per provider orders or at least monthly and as needed, bathing, dressing, grooming, toileting, escorts, transfer assistance, safety checks, blood glucose monitoring, and medication administration. R3's After Visit Summary signed by heart and vascular specialist on February 7, 2025, ordered to record weight daily, bring the recordings to all appointments. Call nurse if weight goes up 3 pounds in one day or 5 pounds in one week. R3's primary provider order signed March 3, 2025, indicated to decrease weight checks from daily to Monday, Wednesday, and Fridays only. No further instructions noted. R3's medication administration record (MAR) dated November 1-6, 2025, instructed staff to check R3's weight Monday, Wednesday, Friday morning at 7:00 a.m., for weight monitoring. No further instruction noted. During interview on November 5, 2025, at 10:55	01940		

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01940	Continued From page 26 a.m., regional director of nursing (RDN)-A stated R3's orders from February ordered daily weights with instructions, then in March, a message was sent to the primary provider indicating weights had been stable so the provider ordered decreased weight checks to Monday, Wednesday, and Fridays but did not include instructions on when/what to report. RDN-A stated the MAR lacked instruction on when to notify the nurse and would need to seek clarification. The licensee's 7.05 Treatment and Therapy Management Plan dated July 2021, indicated for each resident receiving management of prescribed treatments, the licensee would prepare and include in the service plan a written statement of the treatment that would be provided to the resident. The plan also indicated the licensee would include documentation of specific resident instructions relating to the treatment administration and procedures for notifying the registered nurse when a problem arose. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02310 SS=J	144G.91 Subd. 4 (a) Appropriate care and services (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.	02310		

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	36600	A. BUILDING: _____ B. WING _____	11/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SR CARE OF BP	8500 REGENT AVENUE NORTH BROOKLYN PARK, MN 55443

(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
02310	Continued From page 27 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure care and services were provided according to acceptable health care and medical or nursing standards for two of two residents (R3, R8) with consumer bed rails. This practice resulted in a level four violation (a violation that harmed a resident's health or safety, not including serious injury or death, or a violation that was likely to lead to serious injury 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: R3 R3 was admitted on August 9, 2022, with diagnoses including peripheral vascular disease (reduced blood flow to limbs), major depressive disorder, type two diabetes, hypertension, muscle weakness, and atrial fibrillation (abnormal heart rhythm). R3's [licensee] Service Agreement-V5 dated July 29, 2025, indicated R3 received assistance with bathing, dressing, grooming, toileting, escorts, transfer assistance, safety checks, blood glucose monitoring, and medication administration. On November 4, 2025, at 9:15 a.m., the surveyor observed R3's standard full/queen sized bed with a black padded upside down "U" shaped bed rail on the right side of the bed.	02310	During the course of the survey, the licensee took action to mitigate the immediate risk. Noncompliance remained and the scope and level remain unchanged.	

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02310	Continued From page 28 R3's Bed Rail Assessment-V3-Copy-V7 signed August 30, 2025, indicated the following: -R3 displayed poor bed mobility or difficulty moving to a sitting position on the side of the bed; -R3 was using the bed rail for position or re-positioning with or without staff; -bed rail promoted independence; -the registered nurse (RN) educated the resident and/or resident's representative on the risks versus benefits with the use of bed rails; -bed rail model was "Consumer Bed Assist Handle;" -unable to locate manufacturer's guidelines; -bed rail had been inspected and in good working order and had been tightened according to the manufacturer's guidelines; and -bed rail was checked for recall on the Consumer Product Safety Commission (CPSC) website and was not recalled. During observation of the bed rail on November 5, 2025, at 11:32 a.m., the surveyor lifted the mattress up to observe the manufacturer's label clearly labeled on the bar. The following was observed: Medline, REF MDS6800BA and an orange ratchet strap attached to the bed rail underneath the mattress and bed frame (not originally part of the bed rail). On November 5, 2025, at 11:43 a.m., the surveyor accessed the CPSC website which indicated on May 30, 2024, "Medline Industries recalls 1.5 million adult portable bed rails due to serious entrapment and asphyxia hazards; two deaths reported." The notification also indicated the model number was MDS6800BA which was the same as R3's bed rail model.	02310		

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SUITE LIVING SR CARE OF BP	8500 REGENT AVENUE NORTH BROOKLYN PARK, MN 55443

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02310	Continued From page 29 On November 5, 2025, at 12:16 p.m., regional director of nursing (RDN)-A (interim registered nurse) stated bed rail assessments were completed upon use of a bed rail then every 90 days thereafter. During the assessment, the RN would complete a physical inspection of the bed rail to ensure it was secure and have a discussion with the resident and/or resident's representative on the risks versus benefits of using a bed rail. To ensure the bed rails remained secured, a licensed practical nurse (LPN) would complete weekly bed rail checks and document the findings. RDN-A stated an RN checked for recalls every 90 days when the bed rail assessment was completed. RDN-A recalled having a discussion with resident/family regarding safety risks of using R3's bed rail but was not sure if they were notified regarding the recall. When asked why the correct bed rail manufacturer information was not in R3's record, RDN-A could not explain the discrepancy and stated the RN who completed the assessment was no longer working for the licensee. On November 5, 2025, at 12:47 p.m., RDN-A contacted R3's representative via phone to determine if he/she was notified of the recall, which they were not. On November 5, 2025, at 1:00 p.m., RDN-A entered R3's room and asked R3 if he was aware his bed rail was recalled, he stated no. On November 5, 2025, at 3:05 p.m., R3 stated he had the current bed rail since he was admitted to the facility. He also stated changes were made recently to the bed rail by adding a strap. R3's progress note dated August 28, 2025, at	02310		

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02310	Continued From page 30 3:53 p.m., LPN-I noted daughter of R3 wanted to keep the bed rail to assist R3 with transfers in and out of bed. LPN-I wrote she explained to daughter the bed rail was high risk of entrapment due to the width of the opening. LPN-I requested the daughter to obtain a strap to secure the bed rail to the bed frame and the daughter would have one brought in. R3's record lacked: -an accurate assessment of R3's bed rail reflecting the actual manufacturer of R3's bed rail (clearly visible on R3's bed rail); -documentation the licensee checked for recalls of the actual manufacturer of R3's bed rail on the CPSC website; -documentation of installation and use per manufacturer's guidelines (R3's record indicated manufacturer's guidelines were unavailable, and also that the bed rail was installed per manufacturer's guidelines); and -documentation R3/R3's representative were notified R3's bed rail was recalled and information related to interventions to mitigate safety risk. R8 R8 was admitted on February 7, 2022, and had diagnoses of dementia, dizziness and giddiness, restless leg syndrome (strong urge to move the legs), and generalized anxiety disorder. R8's [licensee] Service Agreement-V5 dated September 24, 2025, indicated R8 received assistance with dressing, grooming, bathing, escorts, and medication administration. On November 4, 2025, at 9:00 a.m., the surveyor observed R8 lying on her twin mattress on top of	02310		

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02310	Continued From page 31 a box frame containing drawers underneath. On the right side of the bed was a small oval shaped loop that was on one metal post and the oval was covered with solid black fabric covering the opening. On November 5, 2025, at 11:49 a.m., upon further inspection of the bed rail, the surveyor lifted the mattress and saw the metal post was connected to a rectangular piece of wood on one end and straps were connected to the opposite end laying loosely on the bed frame box. The straps were not attached to the bed frame and the bed rail came completely out. Attached to the bed rail was a label with the following information: "Warning Suffocation/Strangulation/Entrapment Hazard" "Never use product without properly securing it to bed. Incorrect installation can allow product to move away from mattress, bed frame and/or head or foot boards, which can lead to entrapment and death. Included safety strap must be properly secured." R8's most recent and incomplete Bed Rail Assessment dated June 11, 2025, indicated the following: -R8 was using the bed rail for position or re-positioning with or without staff; -R8 was visually challenged; -bed rail promoted independence; -the RN educated the resident and/or resident's representative on the risks versus benefits with the use of bed rails; -bed rail model was "Stander;" -manufacturer's guidelines have been obtained and read, and bed rail has been installed according to the guidelines; -bed rail had been inspected and in good working	02310		

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02310	Continued From page 32 order and had been tightened according to the manufacturer's guidelines; and -bed rail was checked for recall on the CPSC website and was not recalled. R8's manufacturer guideline "Stander" dated August 12, 2021, instructed the consumer to loop the safety strap around the bed frame, re-buckle and tighten safety strap to secure bed rail product against side of the mattress. On November 5, 2025, at 12:16 p.m., RDN-A stated she completed the weekly bed rail check the day prior by pulling at the bed rail and noted it to be unsecured but did not check to see if it was attached to the bed frame. R8's record lacked: -documentation R8's bed rail was actually installed per manufacturer's guidelines; -documentation of physical inspection of bed rail for stability and correct installation; -resident's bed rail use/need assessment was not completed within 90 days of the last assessment (approximately 57 days past due); and -documentation of information related to interventions to mitigate safety risk of an unsecured bed rail. The licensee's 6.28 Side Rails (bed rails) policy dated May 20, 2023, indicated when a resident is utilizing side rails on a bed, the licensee will assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of a safe design and utilized with the manufacturer's guidelines. This policy shall be followed regardless of who owns or is supplying the side rail. The policy also indicated	02310		

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02310	Continued From page 33 the use of physical bed rails would be assessed at least every 90 days, and weekly inspections to ensure the bed rail is in good working order and the nurse would tighten the bed rail as tightly as possible. Licensed nurses would check the CPSC website for recalls on consumer bed rails. The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe". The Minnesota Department of Health (MDH) website last updated October 13, 2025, Assisted Living Resources & Frequently Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to:	02310		

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02310	Continued From page 34 -Purpose and intention of the bed rail; -Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; -The resident's bed rail use/need assessment; -Risk vs. benefits discussion (individualized to each resident's risks); -The resident's preferences; -Installation and use according to manufacturer's guidelines; -Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and -Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE Based on observation, interview, and record review, the licensee failed to ensure care and services were provided according to acceptable health care and medical or nursing standards for one of one resident (R2) who used oxygen therapy. The licensee also failed to ensure care and services were provided according to acceptable health care and medical or nursing standards for two of two residents (R5, R4) who utilized bed rails. The findings include: OXYGEN STORAGE R2 was admitted for assisted living services on February 6, 2025, and admitted to hospice services (end of life support) on September 3, 2025, and had diagnoses including multiple	02310		

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02310	Continued From page 35 sclerosis, right-sided hemiplegia (paralysis) following a stroke, and adult failure to thrive. During observation on November 3, 2025, at 2:05 p.m., the surveyor observed R2 lying in a hospital bed with bilateral raised bed rails awake and welcomed the surveyor into the room for an interview. The surveyor observed the following alongside the wall near the entrance of the room: -three metal cylinder oxygen tanks approximately four inches in diameter and 25 inches in height placed upright in a black crate (oxygen tank storage provided by oxygen company) with white seal attached indicating ready for use; -one same sized metal cylinder oxygen tank within a portable holder and regulator/tubing attached (off but in use when needed); and -two empty same sized metal cylinder tanks unsecured and upright directly on the floor, while one was slightly tilted back leaning against the wall. R2's Individualized Treatment/Therapy Management Plan dated November 4, 2025 (completed during survey), indicated R2 received assistance with oxygen therapy. R2's Medication Administration Record (MAR) dated October 1, 2025, through November 6, 2025, indicated the following: -Oxygen 1-4 LPM (liters per minute) via nasal cannula (tube that provides oxygen through the nasal opening) as needed for comfort. Start date-September 14, 2025, at 11:00 a.m. On October 26, 2025, at 2:01 p.m., the MAR noted initials with a check mark. During interview on November 3, 2025, at 2:57 p.m., unlicensed personnel (ULP)-G stated R2	02310		

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02310	Continued From page 36 did not use her oxygen continuously but did use it daily for periods of time and R2 was able to tell staff when she needed oxygen. During phone interview on November 7, 2025, at 9:10 a.m., regional director of nursing (RDN)-A stated oxygen tanks were supposed to be stored upright in a stand or holder, away from electrical outlets, and was unaware they were stored in that manner. Minnesota Department of Health (MDH)-Oxygen Cylinder Storage Requirements dated April 16, 2020, indicated oxygen cylinders common hazard in a health care facility was storing and handling compressed oxygen in cylinders. Cylinders must be secured (chains or racks) to prevent them from falling over. The licensee's 7.40 Oxygen policy dated July 20, 2021, indicated oxygen cylinders and vessels must remain upright at all times but did not specify how to ensure they stayed upright at all times. BED RAIL ASSESSMENT R5 R5 was admitted for services on July 21, 2025, and had diagnoses including hemiplegia affecting right side following a stroke, type 2 diabetes, history of falls, chronic pain, and epilepsy (seizures). During observation on November 4, 2025, at 9:36 a.m., ULP-B entered R5's room and met R5 while sitting at the computer sitting in her manual wheelchair. The surveyor noted a high/low bed with two metal narrow round bed rails that were securely attached to the bed.	02310		

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02310	Continued From page 37 R5's most current Bed Rail Assessment-V3-Copy-V7 dated July 21, 2025, indicated the following information: -R5 was using the bed rail for position or re-positioning with or without staff; -R5 was incontinent needing assistance; -bed rail promoted independence; -the RN educated the resident and/or resident's representative on the risks versus benefits with the use of bed rails; -bed rail model-Accora STLEV-0-FL1-100 placed on an Accora twin bed; -manufacturer's guidelines have been obtained and read, and bed rail has been installed according to the guidelines; -bed rail had been inspected and in good working order and had been tightened according to the manufacturer's guidelines; and -bed rail was checked for recall on the CPSC website and was not recalled. R5's medical record lacked a current bed rail assessment (approximately 107 days since last assessment). R4 R4 was admitted for services on November 13, 2023, and had diagnoses including type 2 diabetes. During observation on November 4, 2025, at 9:20 a.m., ULP-B brought R4's medications into R4's room and found R4 lying in her hospital bed with upper bilateral bed rails raised. R4's Bed Rail Assessment-V3-Copy-V7 dated March 11, 2025, and September 9, 2025 (approximately 183 days in between	02310		

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02310	Continued From page 38 assessments), indicated the following information: -R4 was using the bed rail for position or re-positioning with or without staff; -bed rail promoted independence; -the RN educated the resident and/or resident's representative on the risks versus benefits with the use of bed rails; -bed rail model-Medline; -measurements of entrapment Zones 1-4; and -bed rails were inspected and in good working order. R4's medical record lacked timely bed rail assessment at least every 90 days. During interview on November 5, 2025, at 12:16 p.m., RDN-A stated RNs would complete bed rail assessments upon admission if they had one, or when a bed rail was discovered. They would inspect straps, check security of the bed rail and tighten if necessary. Bed rail assessments were done every 90 days, but weekly checks were completed by an LPN.	02310		

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 Brooklyn Park
8500 REGENT AVENUE NORTH
Brooklyn Park, MN 55443
Hennepin County
Parcel:

Phone:

License Info

License: HFID 36600

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

Inspection Info

Report Number: F8041251154
Inspection Type: Full - Single
Date: 11/4/2025 Time: 10:15 AM
Duration: minutes
Announced Inspection:
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 Johnnie Johnson and Chabrea Young with Unidine to discuss food service operation. The food service area at this assisted living facility is ran by a third party, Unidine. Facility is required to be licensed and inspected by The City of Brooklyn Park.

Report sent to the Health Regulation Division Nurse Evaluator, Anna Bohnen and facility directors.

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 F8041251154 from 11/4/2025

Chabrea Young
Chef Manager- Unidine

Sarah Conboy,
Public Health Sanitarian Supervisor
651-201-3984
sarah.conboy@state.mn.us