



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 23, 2026

Licensee
Suite Living Senior Care Of Vadnais
580 Liberty Way
Vadnais Heights, MN 55127

RE: Project Number(s) SL33260016

Dear Licensee:

On February 19, 2026, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on September 12, 2025. 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,

A handwritten signature in black ink that reads 'Casey DeVries'.

Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

JMD



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 15, 2026

Licensee

Suite Living Senior Care of Vadnais Heights
580 Liberty Way
Vadnais Heights, MN 55127

RE: Project Number(s) SL33260016

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 September 12, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the September 12, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on September 12, 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) - \$1,000.00

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.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

Also, at the time of this follow-up survey completed on December 17, 2025, we identified the following violation(s):

1890-Prescription Drugs-144g.71 Subd. 20

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

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.

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.

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.

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,

A handwritten signature in black ink, appearing to read 'Jess', with a stylized flourish extending to the right.

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

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33260	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/17/2025
NAME OF PROVIDER OR SUPPLIER SUITE LIVING SENIOR CARE OF VA			STREET ADDRESS, CITY, STATE, ZIP CODE 580 LIBERTY WAY VADNAIS HEIGHTS, MN 55127		
(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 SL33260016-1 From 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 on September 12, 2025. At the time of the survey, there were 27 residents; 27 receiving services under the Assisted Living with Dementia Care license. As a result of the follow-up survey, the following orders were issued and 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 License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the 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}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 510}	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.		
{0 650} SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health	{0 650}			

Minnesota Department of Health

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{0 650}	Continued From page 2 screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by:	{0 650}	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}			
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	{0 800}			

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{0 900}	Continued From page 3	{0 900}			
{0 900} SS=E	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by:	{0 900}			
			Not reviewed during this survey.		

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{01420}	Continued From page 4	{01420}			
{01420} SS=D	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. This MN Requirement is not met as evidenced by:	{01420}			
{01730} SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication	{01730}	Not reviewed during this survey.		

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{01730}	Continued From page 5 management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: 01890 SS=F 144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for	{01730}	Not reviewed during this survey.		
		01890			

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01890	Continued From page 6 immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure accurate prescription labeling for four of four residents (R2, R6, R7, R8) with insulin pens observed during medication administration. 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 medication administration observation on December 16, 2025, at 11:23 a.m., unlicensed personnel (ULP)-M stated R6's blood glucose (BG) was 111. ULP-M set up R6's oral medication then pulled out of the medication cart R6's insulin aspart (Novolog-rapid-acting insulin) FlexPen which showed a white label indicating "DISCARD AFTER 28 DAYS EXP. DATE" with a line to write a date which was blank. ULP-M then dialed the pen to 5 units and administered it to R6. ULP-M and the surveyor observed the following insulin pens: -R2 - Novolog FlexPen-bearing a white label	01890			

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01890	Continued From page 7 indicating "DISCARD AFTER 28 DAYS EXP. DATE" with date "12-13" written in black sharpie marker; -R7 - Lantus Solostar (long-acting insulin)-no label or open date on pen; and -R8 - Humalog KwikPen (rapid-acting insulin)-bearing a white label indicating "DISCARD AFTER 28 DAYS EXP. DATE" with date "12-11" written in black sharpie marker. ULP-M was unsure if the dates listed on R2 and R8's pens were the open date or expiration date. ULP-M brought the 4 pens to registered nurse (RN)-K's attention and RN-K instructed ULP-M to discard R6 and R7's insulin pens because they were not labeled and replace them with new ones. RN-K stated R2 and R8's pens were most likely labeled with the open date and not the expiration date which could be confusing. RN-K asked ULP-M to re-label R2 and R8's pens with the expiration date. At 11:43 a.m., ULP-M set up R2's oral medication then went to R2's room to obtain BG which was 371 and administered 8 units of Novolog insulin. R2 R2's diagnosis included type 1 diabetes mellitus. R2's service agreement signed May 30, 2025, indicated R2 received assistance with insulin administration. R2's provider orders dated September 8, 2025, ordered Novolog FlexPen 100 unit/ml (milliliter). Inject SC (subcutaneous-under the skin) with meals three times daily based on sliding scale: if BG 70-199, give 2 units; 200-249, give 5 units; 250-299, give 6 units; 300-349, give 7 units; 350-399, give 8 units; 400-600, give 9 units. R6	01890			

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01890	Continued From page 8 R6's diagnosis included type 1 diabetes. R6's service agreement dated February 18, 2025, indicated R6 received assistance with insulin administration. R6's provider orders dated September 25, 2025, ordered insulin aspart (Novolog) 100 unit/ml. Inject 4 units with breakfast and dinner. Inject 5 units at lunch; plus sliding scale; if BG 120-149, give 1 unit; 150-199, give 2 units; 200-the rest of the order was not visible. R7 R7's diagnosis included type 2 diabetes mellitus. R7's service agreement signed December 18, 2024, indicated R7 received assistance with insulin administration. R7's provider orders signed August 12, 2025, ordered Lantus Solostar, 34 units SC daily. R8 R8's diagnosis included type 2 diabetes mellitus with diabetic neuropathy. R8's service agreement signed October 13, 2025, indicated R8 received assistance with insulin administration. R8's provider orders signed September 10, 2025, ordered Humalog KwikPen 100 unit/ml, inject 8 units with meals and inject per sliding scale: if BG 70-139, no additional insulin; 140-174, 1 unit, 175-209, 2 units; 210-244, 3 units; 245-279, 4 units; 280-314, 5 units; 315-349, 6 units; 350-384, 7 units; 385-419, 8 units; 420-999, 9 units. The manufacturer's guidelines for the Lantus	01890			

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01890	Continued From page 9 injection pen dated August 2022, recommended insulin be discarded 28 days after being removed from the refrigerator. The manufacturer's guidelines for the Humalog injection pen revised July 2023, recommended insulin be discarded 28 days after being removed from the refrigerator. The manufacturer's guidelines for the Novolog injection pen dated February 2025, recommended insulin be discarded 28 days after being removed from the refrigerator. The licensee's 7.11 Medication Storage policy dated July 2021, indicated when medications were managed and stored by licensee, medications would be kept securely locked and stored per manufacturer's directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
{01960} SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs.	{01960}			

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{01960}	Continued From page 10	{01960}			
	This MN Requirement is not met as evidenced by:		Not reviewed during this survey.		
{01970} SS=F	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by:	{01970}			
			Not reviewed during this survey.		
{02310} SS=G	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 observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for one of one resident (R3) who utilized side rails. This practice resulted in a level three violation (a	{02310}			

Minnesota Department of Health

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{02310}	Continued From page 11 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 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 observation December 16, 2025, at 10:15 p.m., the surveyor entered R3's room and noted a hospital style bed with raised bilateral (two) upper side rails with slight side to side wobble, but secured to the bed. The surveyor observed labels to include the following information: Probasics Semi-Electric Single Motor Bed Item #HBSMSS on the bed frame, and REF MDS89697 on the side rail. R3's record included the following: -photo of R3's side rails dated September 10, 2025; -Side Rail Measurements form dated September 10, 2025; -User Instructions for MDS89697 half-length clamp-on rails; -Semi-Electric Bed User Manual & Entrapment Guide for item #HBSMBEM/HBSMSS; -Bed Rail (side rail) Assessment dated September 10, 2025; -Bed Rail Assessment dated September 21, 2025; and -Weekly Bed Rail Inspection/Assessment dated November 20, 2025, indicated R3 "received new Hospital bed w/bilateral side rails via insurance 10/01/25." R3's record lacked a reassessment of R3's new hospital bed with bilateral side rails (exact same	{02310}			

Minnesota Department of Health

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{02310}	Continued From page 12 model) that became available on October 1, 2025. On December 16, 2025, at 1:50 p.m., regional director of operations (RDO)-E explained clinical nurse supervisor (CNS)-A was no longer employed to ask if a reassessment was completed. RDO-E could not locate the requested information and stated a reassessment should have been completed when the new bed arrived despite being the same model. The licensee's 6.28 Side Rails policy revised May 10, 2023, indicated a nurse would complete a side rail assessment at the time of move in, change in condition, and/or upon discovery of a new/different rail. Physical side rails would be assessed for safety during each reassessment by ensuring side rails were installed securely and tightened as tight as possible, in good operating condition, and side rail design is consistent with Food and Drug Administration's (FDA) 2006 recommended dimensional measurement to reduce entrapment. The Minnesota Department of Health (MDH) website, 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,	{02310}			

Minnesota Department of Health

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{02310}	Continued From page 13 "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." No further information was provided.	{02310}			
{02320} SS=D	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:	{02320}	Not reviewed during this survey.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 23, 2025

Licensee
Suite Living Senior Care of Vadnais, LLC
580 Liberty Way
Vadnais Heights, MN 55127

RE: Project Number(s) SL33260016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 12, 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 - 1760 - 144g.71 Subd. 8 - Documentation Of Administration Of Medication - \$3,000.00

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$4,500.00**. 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

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33260	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/12/2025
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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: SL33260016-0 On September 8, 2025, through September 12, 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 24 residents; all of whom were receiving services under the Assisted Living Facility with Dementia Care license. On September 10, 2025, an immediate correction order was issued for tag identification number 2310. On September 11, 2025, an immediate correction order was issued for tag identification number 1760. During the course of the survey, the licensee took action to mitigate the imminent risks identified in orders 2310 and 1760. Noncompliance remained	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.		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 000	Continued From page 1 and the scope and levels remain unchanged.	0 000			
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 infection control program to comply with accepted health care, medical and nursing standards for infection control for one of two unlicensed personnel ((ULP)-B) during medication administration to 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 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).	0 510			

Minnesota Department of Health

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0 510	Continued From page 2 The findings include: During morning medication administration observation on September 9, 2025, starting at 8:35 a.m., ULP-B attempted to obtain a blood pressure by going to R6's room (who was not there). ULP-B came back to medication cart located near the dining room and proceeded to finish charting. At 8:40 a.m., R9 came to the table next to the medication cart where ULP-B began setting up medications without performing hand hygiene (HH). R9 took his medications then pointed out to ULP-B that there were pills on the floor near the medication cart. ULP-B located two pills and picked them up and placed them into a medication cup. She brought them to the nursing office then came back to the cart. R6 came to the medication cart requesting her pain patch. ULP-B applied gloves without HH then placed the patch to R6's left shoulder. ULP-B removed gloves then performed HH for the first time since the start of observation. ULP-B set up R11's medications at the medication cart then proceeded to R11's room. ULP-B applied gloves and administered eye drops, applied a pain patch to lower back and administered oral medications. ULP-B removed gloves then returned to medication cart to get the blood pressure machine. ULP-B did not perform HH after assisting R11 and before setting up R2's medication. At 9:53 a.m., ULP-B did not perform HH before setting up R5's medications. At 10:25 a.m., ULP-B applied gloves to administer two eye drops to R4 then removed gloves, walked out of room, found R5 in the hallway and administered his medication without performing HH in between residents. During midday medication administration observation on September 9, 2025, starting at 11:38 a.m., ULP-B checked R6's blood glucose	0 510			

Minnesota Department of Health

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0 510	Continued From page 3 prior to setting up her insulin. ULP-B applied the needle to the insulin pen without wiping the rubber stopper with an alcohol prep pad (helps reduce contamination of needle) prior to setting the insulin dose then injected it to R6's abdomen. ULP-B removed gloves but did not perform HH. R2 came to the table shortly after R6, ULP-B applied gloves without HH, checked R2's blood glucose by obtaining a drop of blood from her middle finger. ULP-B used an alcohol prep pad to wipe the drop of blood off the finger then discarded the wipe into the trash and proceeded to the touch the mouse of the computer to access the electronic medication administration record (eMAR) for insulin dosing. Again, without wiping rubber stopper of insulin pen, ULP-B applied the needle, set the dose, and administered the insulin of R2's right lower quadrant without first wiping the skin with an alcohol prep pad to reduce surface contamination from entering the tissue. ULP-B then removed gloves, no HH, set up oral medications. At 11:55 a.m., ULP-B went to R8's room, applied gloves without HH, cleaned right pointer finger with an alcohol prep pad, obtained a drop of blood. Removed gloves, went back to medication cart, set up insulin, then back into R8's room, applied gloves without HH, injected insulin into stomach without wiping with alcohol prep pad. No HH after insulin administration. At 12:08 p.m., ULP-B applied gloves, met R7 at the dining room table, and without wiping R7's finger with alcohol prep pad, pricked her finger to obtain a blood sample for testing. ULP-B then opened the alcohol prep pad to wipe the blood away from her finger. ULP-B did not clean R7's abdomen prior to inject insulin. No HH was performed when completed. ULP-B's Injectable Diabetic Medication Competency dated July 1, 2025, indicated clinical	0 510			

Minnesota Department of Health

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0 510	Continued From page 4 nurse supervisor (CNS)-A observed ULP-B to be competent in insulin administration including the following steps: hand washing, applying gloves, wiping the rubber stopper with alcohol prep pad, wipe skin area with alcohol prep pad, and hand washing after glove removal. ULP-B's OSHA [Occupational Safety and Health Administration] & Infection Control Skill Competency dated July 1, 2025, indicated ULP-B was competent in hand washing and alcohol-based rub [hand sanitizing]. During interview on September 10, 2025, at 3:08 p.m., CNS-A stated he would need to follow up regarding whether or not staff were supposed to be wiping the rubber stopper of the insulin pen, but did state staff were expected to wipe the skin with alcohol wipe prior to administering insulin. CNS-A also expected hand hygiene to be performed between each medication pass. The licensee's 7.31 Blood Sugar Testing-Single Equipment Use policy dated July 2021, directed staff to wash hands, apply gloves, perform the blood glucose test, remove soiled gloves, wash hands, then document the results of the reading. The licensee's 8.07 Gloves policy dated July 20, 2021, indicated the procedure when using gloves were as follows: wash hands, apply gloves to both hands, remove contaminated material and place into proper receptacle, remove gloves and dispose in proper receptacle, rewash hands. The licensee's 8.09 Hand Washing policy dated July 20, 2021, indicated when conducting a procedure requiring the use of gloves, proper hand hygiene would be completed before applying gloves and after removing gloves.	0 510			

Minnesota Department of Health

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0 510	Continued From page 5 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the employee record contained the required content for one of unlicensed personnel ((ULP)-B).	0 650			

Minnesota Department of Health

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0 650	Continued From page 6 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: ULP-B was hired on September 26, 2017, under the licensee's comprehensive licensure and began providing assisted living services to residents on August 1, 2021. On September 9, 2025, from 8:25 a.m. through 12:15 p.m., the surveyor observed ULP-B administer medication (oral, topical, eye drops, injection, inhaler, nebulizer, and nasal spray) and treatments to multiple residents. ULP-B's training record included documentation of training and/or demonstrated competency of the following: -online training on medication administration including all routes completed by September 30, 2017; -nebulizer competency dated October 5, 2017; -insulin pen competency dated April 5, 2018, and July 1, 2025; -Asmanex Twisthaler (for asthma) and Stiolto Respimat inhaler (relaxes airway) competency dated July 1, 2025; -Naloxone nasal spray (for suspected overdose) competency dated July 1, 2025; -Epi-Pen (rescue injection for severe allergic reaction) competency dated July 1, 2025; and	0 650			

Minnesota Department of Health

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0 650	Continued From page 7 -glucose testing competency dated October 5, 2017, and July 1, 2025. ULP-B's training record lacked documentation of demonstrated competency on the following: -oral medication administration; -nasal spray administration (Naloxone nasal spray has different procedures); -topical administration including creams, ointments, and patches; and -eye drop administration. On September 12, 2025, at 11:38 a.m., regional director of operations (RDO)-E stated after checking ULP-B's physical training file, the licensee could not locate the missing medication competencies. RDO-E stated the current corporate trainer used to work at this facility and stated ULP-B had been trained on medication but did not document it. RDO-E explained additional training/competencies were completed on July 1, 2025, after completing an audit on employee records. 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	0 650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33260	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/12/2025
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0 775	Continued From page 8	0 775			
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 September 10, 2025, at approximately 10:00 a.m., survey staff toured the facility with regional director of operations (RDO)-E. 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 passing through the exit door in the enclosed vestibule. As a result, occupants shall pass through two locked controlled egress doors and an exit door before accessing the exterior.	0 775			

Minnesota Department of Health

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0 775	Continued From page 9 Building occupants shall not be required to pass through more than one door equipped with a controlled egress lock before entering an exit. On September 10, 2025, RDO-E stated she understood the requirement and would discuss with others. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 775			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 800			

Minnesota Department of Health

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0 800	Continued From page 10 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 September 10, 2025, at approximately 10:00 a.m., survey staff toured the facility with regional director of operations (RDO)-E. The following was observed. GENERAL MAINTENANCE: In resident unit 15 the closet door was off the track and had a sign stating the door would fall. This had the potential to cause injury to staff or the resident. The dryer vent in the assisted living wing was damaged and creased. This has the potential to collect lint in the dryer vent and create a fire hazard. On September 10, 2025, RDO-E acknowledged the deficiencies with accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 900 SS=E	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing;	0 900			

Minnesota Department of Health

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0 900	Continued From page 11 (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and execute a written contract with the required content for five of six residents (R5, R12, R13, R14, R15). 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	0 900			

Minnesota Department of Health

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0 900	Continued From page 12 situation has occurred repeatedly; but is not found to be pervasive). The findings include: The licensee's Current Resident Roster: State Evaluations form dated September 8, 2025, indicated R5, R12, R13, R14, and R15, were admitted to licensee on July 10, 2019, July 8, 2020, June 2, 2021, October 19, 2017, and November 20, 2019, respectively. During observation on September 9, 2025, at 9:53 a.m., unlicensed personnel (ULP)-B set up R5's morning medications at the medication cart within a common area. At 10:07 a.m., ULP-B entered R5's room and provided R5 his oral medications and a box of his medicated creams then walked out. During observation on September 9, 2025, at 12:15 p.m., ULP-B checked R12's blood glucose by placing the meter to the sensor on R12's left bicep and got a blood glucose reading of 149. R12 was halfway through her lunch at that time. R5, R12, R15's record included a two-page document titled Assisted Living with Dementia License HFID: 33260 Residential Lease Agreement signed July 11, 2025, August 1, 2025, and July 12, 2025, respectively. R13 and R14's record included a signed, but undated two-page document titled Assisted Living with Dementia License HFID: 33260 Residential Lease Agreement. R5, R12, R13, R14, and R15's record lacked evidence the contract had been fully executed as the facility must:	0 900			

Minnesota Department of Health

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0 900	Continued From page 13 - give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed; and -the resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. On September 11, 2025, at 3:47 p.m., regional director of operations (RDO)-E stated the licensee's sister facility had contract issues, so the licensee did an audit of their current residents and attempted to fix the issue mid-July. RDO-E noted the licensee only sent the front signature page (two-pages) to the residents mentioned above but did not know why the entire contract was not given. The licensee's 1.05 Signing an Assisted Living Contract policy dated August 1, 2020, indicated when a prospective resident decided to move into the facility, a signed assisted living contract would be signed and received by the facility. It also indicated to emphasize to the prospective resident and/or responsible person that the assisted living contract was a legal, binding contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900			
01420 SS=D	144G.62 Subd. 2 Delegation of assisted living services	01420			

Minnesota Department of Health

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01420	Continued From page 14 (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. 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 one of two employees (unlicensed personnel (ULP)-B) 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 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 facility tour with licensed assisted living	01420			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33260	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/12/2025
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01420	Continued From page 15 director (LALD)-D on September 8, 2025, at 11:45 a.m., the surveyor observed within a secured memory care unit one resident sitting in a Broda chair and was waiting at the dining room table to be served lunch. ULP-B was hired on September 26, 2017, under the licensee's comprehensive home care licensure and began providing assisted living services to residents on August 1, 2021. The licensee's staff schedule dated September 8-14, 2025, indicated ULP-B was scheduled to work 6:00 a.m. through 2:00 p.m. on September 11, 2025, as the medication passer for the memory care unit. ULP-B's employee record lacked training and competency evaluation on use of Broda chairs. During interview on September 12, 2025, at 11:38 a.m., regional director of operations (RDO)-E explained if documentation of Broda chair competency was not in ULP-B's 2025 training record, then ULP-B did not receive the training. RDO-E stated the licensee began training new hires at orientation recently and staff hired prior to that change would not have received training unless the facility RN did the training. 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.	01420			

Minnesota Department of Health

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01420	Continued From page 16 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01420			
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to	01730			

Minnesota Department of Health

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01730	Continued From page 17 documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management record with the required content for one of one resident (R11) 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 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: R11's diagnoses included dementia, hypertension (high blood pressure), kidney stones, and hyperlipidemia (high cholesterol). R11's [licensee name] Service Agreement-V5	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33260	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/12/2025
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01730	Continued From page 18 signed September 3, 2025, indicated R11 required assistance with medication administration and management. R11's medication assessment dated September 3, 2025, indicated R11 required assistance with administration including eye drops and storage of all medications. R11's Individualized Medication Management Plan (IMMP) dated September 3, 2025, indicated the following: -medication administration by facility staff; and -medications are stored in locked medication cart and medication room. During observation on September 9, 2025, at 9:10 a.m., unlicensed personnel (ULP)-B set up R11's omeprazole (acid reflux), urea cream (for dry skin), furosemide (diuretic), ferrous sulfate (iron supplement), apixaban (anticoagulant), ULP-B stated "Flonase is in resident's room," losartan (lowers blood pressure), acetaminophen (pain reliever), "eye drops in his room," clotrimazole powder for groin, "administered already," and lidocaine patch (for pain). ULP-B brought R11's medications to his room, applied gloves to administer eye drop sitting on R11's table. R11 stated he had already taken his Flonase spray earlier in the morning (was on same table as eye drops), then applied R11's lidocaine patch to his lower back. R11's IMMP did not indicate whether R11 could self-administer certain medications and how those medications would be stored. On September 12, 2025, at 11:20 a.m., clinical nurse supervisor (CNS)-A indicated for residents that could self-administer medication, would be	01730			

Minnesota Department of Health

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01730	Continued From page 19 indicated in their medication management plan. The licensee's 7.03 Medication Management Individualized Plan dated July 2021, indicated for each resident at [licensee name] receiving medication management services, the licensee would develop and maintain a current individualized medication management record for each resident based on the resident's assessment that much contain the following: -a description of storage of medications based on the resident's needs and preferences, risk for diversion, and consistent with the manufacturer's direction; and -documentation of specific resident instructions relating to the administration of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01760 SS=K	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.	01760			

Minnesota Department of Health

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01760	Continued From page 20 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication orders were accurately administered for six of eight residents (R2, R5, R6, R8, R9, R11). 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 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: TRANSCRIPTION ERROR R2 was admitted for assisted living services on October 9, 2023, and had diagnoses including type 1 diabetes, chronic atrial fibrillation, hypertension, and transient cerebral ischemic attack (stroke). R2's signed [licensee name] Service Agreement dated May 30, 2025, indicated R2 received assistance with medication administration and blood glucose checks. R2's provider orders dated May 1, 2025, indicated by the provider glucose results were reviewed and ordered to change mealtime Novolog insulin to: -give at meals three times daily. For blood glucose (BG) less than 70, refer to Hypoglycemia Treatment Protocol. For BG 70-199, give two units. For BG 200-249, give 4 units. For BG	01760	During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.		

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER SUITE LIVING SENIOR CARE OF VA		STREET ADDRESS, CITY, STATE, ZIP CODE 580 LIBERTY WAY VADNAIS HEIGHTS, MN 55127			
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01760	Continued From page 21 250-299, give 5 units. For BG 300-349, give 6 units. For BG 350-399, give 7 units. For BG 400 or greater, give 8 units. During observation on September 9, 2025, at 11:48 a.m., R2 was at the dining room table near the medication cart within the smaller dining room. Unlicensed personnel (ULP)-B checked R2's BG using a lancet (needle) to right middle finger. BG was 457 milligrams per deciliter (mm/dL). ULP-B administered 8 units of Novolog insulin per R2's electronic medication administration record (eMAR). R2's September eMAR dated September 1-9, 2025, indicated the following: Administer Novolog Flex Pen 100 unit/milliliter (ml), inject as per sliding scale-if 70-199, give 1 unit, 200-249, give 4 units, 250-299, give 5 units, 300-349, give 6 units, 350-399, give 7 units, 400-600, give 8 units and call nurse/doctor, subcutaneously three times a day. During observation on September 10, 2025, at 11:39 a.m., ULP-C checked R2's BG and result was 251 mg/dL. ULP-C set up 5 units of Novolog per R2's sliding scale. The surveyor observed there was a change in the sliding scale. R2's eMAR dated September 10, 2025, indicated Novolog sliding scale range 70-199 change from 1 unit to 2 units. On September 10, 2025, at 3:08 p.m., clinical nurse supervisor (CNS)-A stated when the surveyor requested R2's orders, he noted he missed transcribing the sliding scale order from May 1, 2025, so he changed it upon discovery. NEAR MISS	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33260	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/12/2025
NAME OF PROVIDER OR SUPPLIER SUITE LIVING SENIOR CARE OF VA			STREET ADDRESS, CITY, STATE, ZIP CODE 580 LIBERTY WAY VADNAIS HEIGHTS, MN 55127		
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01760	Continued From page 22 R5 R5 was admitted for assisted living services on July 10, 2019, and admitted to hospice (end of life care) on May 27, 2025. R5 had diagnoses including acute kidney failure, wedge compression fracture of third thoracic vertebra, cerebrovascular disease, and history of falls. R5 signed [licensee name] Service Agreement dated July 21, 2025, indicated R5 received assistance with medication administration and management, dressing and grooming, mechanical lift transfers, toileting, compression socks, and safety checks. During observation on September 9, 2025, at 9:53 a.m., ULP-B set up the following 8:00 a.m. medications for R5. The following medications were set up and put into a medication cup: haloperidol 0.5 mg (comfort medication) one tablet; mirabegron 25 mg one tablet; duloxetine 60 mg one capsule; acetaminophen 500 mg two caplets; levothyroxine 25 micrograms (mcg) plus 200 mcg; phenytoin 100 mg two capsules; furosemide 20 mg ½ tablet; loratadine 10 mg one tablet; gabapentin 100 mg one capsule; Eliquis 5 mg one tablet; Breo tablet, inhale one tablet; and albuterol sulfate, nebulize one vial. The surveyor also observed Morphine 5 mg on the eMAR, but ULP-B did not set up the Morphine. At 10:07 a.m., ULP-B entered R5's room to hand R5 his medications and water. ULP-B then walked out. The surveyor thought at the time that ULP-B was going to return, but she didn't. The surveyor observed R5 take his medications then went to find ULP-B at the medication cart. At 10:17 a.m., the surveyor asked ULP-B if she had given R5 his Morphine; ULP-B checked on the eMAR which was documented as given. ULP-B then went to the medication cart and pulled out the narcotic log	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33260	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/12/2025
NAME OF PROVIDER OR SUPPLIER SUITE LIVING SENIOR CARE OF VA		STREET ADDRESS, CITY, STATE, ZIP CODE 580 LIBERTY WAY VADNAIS HEIGHTS, MN 55127			
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01760	Continued From page 23 book and looked up R5's morphine. It was not documented that it was signed out. ULP-B stated it was not given so she retrieved the bubble pack containing R5's morphine 5 mg, and signed out one tablet and placed it into the medication cup and gave it to R5 while he was in the hallway in the presence of CNS-A. R5's hospice order dated September 5, 2025, indicated the following: -start Morphine 5 mg tablets by mouth (PO) twice a day (BID) for pain or discomfort. R5's eMAR dated September 1-11, 2025, indicated morphine sulfate 5 mg solutab, give one tablet sublingually two times a day for pain and discomfort. R9 R9 was admitted for assisted living services on May 24, 2022, and had diagnoses of Parkinson's disease, seizures, stroke, chronic diastolic heart failure, and altered mental status. R9's [licensee name] Service Agreement-V5 dated May 30, 2025, indicated R9 received medication administration and management, dressing and grooming, toileting, bathing, mobility, and safety checks. During observation on September 9, 2025, at 8:40 a.m., ULP-B was at the medication cart located in the small dining room near the fish tank. R9 was brought to the table in his manual wheelchair next to the medication cart by another ULP. ULP-B set up the following medications: sertraline 150 mg one and one-half tablets; levothyroxine 100 mg one tablet; carbidopa-levodopa extended release 25-100 mg three tablets; vitamin B-12 500 mcg one tablet;	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33260	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/12/2025
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01760	Continued From page 24 Senna 8.6 mg one tablet; atomoxetine 10 mg one capsule; gabapentin 100 mg one capsule; punched another dose of levothyroxine 100 mg (second card) one tablet; Eliquis 5 mg one tablet; pyridostigmine bromide 60 mg (muscle weakness) one tablet; and fludrocortisone acetate 0.1 mg (for Parkinson's disease) one tablet. The surveyor noted on the eMAR that levetiracetam 750 mg (seizures) two tablets, was selected "Y" as set up but did not see ULP-B punch the medication into the medication card. The surveyor pointed to "levetiracetam" and asked if that was set up, ULP-B said yes then seemed confused so she went into the medication cart to find the medication bubble pack and could not locate it. ULP-B went to the nursing office where overstock medications were kept and found a bubble pack and brought it to the medication cart. The bubble pack was brand new and contained 28 individual bubbles holding a large oval orange pill. ULP-B then confirmed the medication had not been punched out and started circling every two bubbles to indicate two pills for each medication pass. ULP-B then punched two pills into the medication cup. The surveyor asked if R9 had been getting Levetiracetam, and ULP-B stated yes and that he had just ran out. R9's discharge orders dated March 15, 2025, ordered levetiracetam 750 mg two tablets by mouth two times daily. R9's eMAR dated September 1-11, 2025, indicated R9 took levetiracetam 750 mg two tablets by mouth twice a day. ULP-B would have given R9 an extra dose of levothyroxine in the place of leveitracetam, if the surveyor would not have intervened.	01760			

Minnesota Department of Health

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01760	Continued From page 25 INCORRECT INSULIN ADMINISTRATION R6 R6 was admitted for assisted living services on February 1, 2025, and had diagnoses including type 1 diabetes, generalized anxiety disorder, and major depressive disorder. R6's [licensee name] Service Agreement-V5 dated February 18, 2025, indicated R6 received assistance with medication administration, treatment administration, dressing and grooming, bathing, and safety checks. During observation on September 9, 2025, at 11:38 a.m., ULP-B checked R6's blood glucose (BG) and it read 178 mg/dL. ULP-B pulled out insulin aspart flex pen 100 unit/ml, placed a needle on the pen, then turned the dial to 2 units, pushed the button to waste the insulin then set it 2 units again. ULP-B injected the insulin in R6's right lower quadrant of her abdomen. ULP-B verbally confirmed to the surveyor that she gave 2 units of insulin to R6. R6's provider orders dated August 19, 2025, ordered the following for insulin aspart: -inject 4 units subcutaneously three times daily with meals. Plus sliding scale (SS): 120-149=1 unit; 150-199=2 units; 200-249=4 units; 250-299=6 units; 300-349=8 units; 350 + =10 units. Hold for BG less than 120. R6's eMAR dated September 1-11, 2025, indicated the same information as the provider's order. R6 should have received 6 units per base and SS orders, rather than than the 2 units ULP-B administered.	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33260	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/12/2025
NAME OF PROVIDER OR SUPPLIER SUITE LIVING SENIOR CARE OF VA		STREET ADDRESS, CITY, STATE, ZIP CODE 580 LIBERTY WAY VADNAIS HEIGHTS, MN 55127			
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01760	Continued From page 26 R8 R8 was admitted for assisted living services on January 10, 2023, and had diagnoses including type 2 diabetes, heart failure, peripheral vascular disease, and major depressive disorder. R8's [licensee name] Service Agreement-V5 dated January 10, 2025, indicated R8 received assistance with medication administration, treatment administration, dressing and grooming, transfers with mechanical lift, toileting, bathing, and safety checks. During observation on September 9, 2025, at 11:55 a.m., ULP-B went to R8's room to obtain his BG by pricking his finger and obtaining a blood drop using a glucometer. The BG result was 296 mg/dL. ULP-B then went back to the medication cart and entered in the eMAR #264 under BG result. The eMAR instructed ULP-B to administer 4 units of Humalog Kwik Pen 100 unit/ml. ULP-B primed the pen by wasting 2 units of insulin, then set the pen to 4 units and showed the surveyor. ULP-B administered the insulin into R8's left lower quadrant of his abdomen. R8's prescriber orders dated January 13, 2025, ordered Humalog Kwik pen 100 units/ml, inject 8 units subcutaneously with meals. The order also included a sliding scale based on BG to be administered with base dose. If BG 70-139, give 0 additional insulin; 140-174, give 1 additional unit; 175-209, give 2 additional units; 210-244, give 3 additional units; 245-279, give 4 additional units; 280-314, give 5 additional units; 315-349, give 6 additional units; 350-384, give 7 additional units; 385-419, give 8 additional units; 420-999, give 9 additional units subcutaneously with each meal.	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33260	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/12/2025
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01760	Continued From page 27 R8's eMAR dated September 1-11, 2025, indicated the exact same Humalog instruction as written by the provider. ULP-B wrote down an incorrect BG of 264, rather than 296. Based on R8's actual BG of 296, R8 should have received a total of 13 units (8 base+5 SS). ULP-B only administered 4 units. BLOOD PRESSURE CHECK R6 During observation on September 9, 2025, at 8:31 a.m., the surveyor observed R6 at the table near the medication cart and had administered medications to her then she left (the surveyor did not see ULP-B set up R6's medications). ULP-B was charting on R6's eMAR indicating medications were given and under amlodipine 10 mg, the eMAR prompted R6 to enter a blood pressure. ULP-B then retrieved a blood pressure machine and proceeded to R6's room but could not find her in there and stated, "she must be outside smoking." ULP-B then went to the medication cart and charted "refused" under another medication for R6. Another resident then arrived to the medication cart area where ULP-B began setting up medications. At 9:43 a.m., ULP-B entered 124/76, pulse 79, under R6's eMAR and the surveyor noted when the cursor was in within the blood pressure box, it popped up a history of number entered previously, and ULP-B used those numbers to enter the blood pressure and pulse. The surveyor had been with ULP-B the entire time and did not observe her take a blood pressure on R6. R6's provider orders signed February 17, 2025, ordered amlodipine besylate 10 mg one tablet by mouth one time a day for high blood pressure. Hold all blood pressure medications if systolic blood pressure (top number) is less than 100, or	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33260	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/12/2025
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01760	Continued From page 28 diastolic (bottom number) is less than 50 and update the provider. R6's eMAR dated September 1-11, 2025, indicated the same instructions as the provider ordered. R11 R11 was admitted for assisted living services on September 3, 2024, and had diagnoses including hypertension, stroke, type 2 diabetes, chronic venous hypertension with ulcer of bilateral lower extremity, and long term use of anticoagulants. R11's [licensee name] Service Agreement-V5 dated September 3, 2025, indicated R11 received assistance with medication administration, dressing and grooming, toileting, bathing, transfers, treatment, and safety checks. During observation on September 9, 2025, at 9:15 a.m., ULP-B set up the following medication for R11: furosemide 40 mg one tablet, ferrous sulfate 325 mg one tablet, apixaban 5 mg one tablet, losartan 25 mg one tablet (the eMAR indicated a blood pressure was required), and acetaminophen extended release 500 mg two tablets. ULP-B entered R11's room where R11 was sitting in his power wheelchair. ULP-B gave R11 his medications and he took them. ULP-B then administered one drop of eye drops in each eye, and applied a lidocaine 5% pain patch to R11's lower back. ULP-B went back to the medication cart to get the blood pressure machine and went back to R11's room and took his blood pressure on his wrist. The reading was 129/67, pulse 52. ULP-B then went back to the medication cart and entered in R11's eMAR 127/62, which was incorrect.	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33260	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/12/2025
NAME OF PROVIDER OR SUPPLIER SUITE LIVING SENIOR CARE OF VA			STREET ADDRESS, CITY, STATE, ZIP CODE 580 LIBERTY WAY VADNAIS HEIGHTS, MN 55127		
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01760	Continued From page 29 R11's provider orders dated April 24, 2025, ordered losartan 25 mg. The order did not indicate additional instructions for administration. R11's provider orders dated May 28, 2025, ordered staff to hold losartan if systolic blood pressure was less than 100. ULP-B administered blood pressure medication to R6 and R11 prior to taking a blood pressure as instructed. During interview on September 10, 2025, at 3:08 p.m., CNS-A stated he was "deflated about [name of ULP-B]" and expected the medication passers to be aware how critical those medications were and that it was paramount to give the correct doses and on time. CNS-A explained staff were trained and deemed competent to administer medications. If inconsistencies were discovered, they would investigate. He stated they needed a new routine to follow up on staff performance and make sure things are being done correctly. CNS-A stated he was not made aware of any concerns regarding ULP-B's medication administration. ULP-B's Injectable Diabetic Medication Competency dated July 1, 2025, indicating ULP-B was deemed competent by CNS-A to administer insulin. ULP-B's Vital Signs form dated October 5, 2017, indicated ULP-B was competent on taking a resident's manual blood pressure. The licensee's 7.15 Medication & Treatment-Administration & Delegation policy dated July 2021, indicated when administration of medications or treatment/therapy are delegated	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33260	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/12/2025
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01760	Continued From page 30 or assigned to unlicensed personnel, licensee would ensure the registered nurse has instructed the ULP in proper methods with respect to each resident to administer the medications or perform treatment/therapy, and the ULP has demonstrated the ability to competently follow the procedures. The licensee's 7.16 Medications & Treatment Orders-Implementing policy dated July 2025, indicated medication and treatment/therapy orders received by Suite Living must be implemented on the next business day. The policy also stated upon receipt of a medication and/or treatment order, whether new or change of order from an authorized prescriber, a licensed nurse must take action to implement the order on the next business day, unless the resident is on hospice. The licensee's 7.24 Medication Error policy dated July 20, 2021, indicated for the safety of the residents at [licensee name], the facility has a goal of zero medication errors. In the event an error occurs, staff will document, track, and resolve medication administration errors for quality improvement. Staff will be retrained if necessary. The licensee's 7.36 Insulin Pen policy dated August 1, 2021, indicated only properly trained staff of [licensee name] may provide medication assistance or administration. Medications always needed to be administered according to the "6 Rights," right person, right medication, right time, right route, right dose, and right chart/record to document that the medication was taken. The National Institutes of Health (NIH)'s article titled Incorrect Insulin Administration: A Problem	01760			

Minnesota Department of Health

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01760	Continued From page 31 that Warrants Attention, dated January 2016, indicated incorrect administration of insulin (too little, too much, or at the wrong times) could result in serious and life-threatening events such as hypoglycemia (low blood sugar causing shaking, weakness, sweating, chills, increased heart rate, dizziness, seizures, coma, and/or death), hyperglycemia (high blood sugar causing thirst, headaches, blurred vision, fatigue, fruity-smelling breath, confusion, coma, and/or death), and diabetic ketoacidosis (a life-threatening complication of high blood sugar that occurs when the body does not have enough insulin to process blood sugar resulting in blood acids called ketones building up in the blood to dangerous levels). No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE Based on observation, interview, and record review, the licensee failed to ensure medication orders were accurately administered and/or documented for five of eight residents (R2, R4, R6, R8, R10) 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:	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33260	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/12/2025
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01760	Continued From page 32 EYE DROP ADMINISTRATION R4 was admitted for assisted living services on December 31, 2024, and had diagnoses including dementia, psychotic disturbance, mood disturbance, and anxiety. R4's care plan with an as of date September 9, 2025, indicated R4 received assistance with medication administration. R4's provider order dated August 26, 2025, ordered prednisolone acetate 1%-instill one drop into left eye four times per day. R4's provider order dated August 28, 2025, ordered ketorolac 0.5%-instill one drop into left eye four times a day. R4's electronic medication administration record (eMAR) dated September 1-9, 2025, indicated R4 received the following eye drops: -ketorolac tromethamine ophthalmic solution 0.5% (for acute inflammation)-instill one drop to left eye four times a day. Wait 5 minutes between drops; and -prednisolone acetate ophthalmic suspension 1% (for inflammation)-instill one drop in left eye four times a day. Allow 5 minutes between drops. During observation on September 9, 2025, at 10:20 a.m., ULP-B brought R4's oral medication and two eye drops (ketorolac tromethamine ophthalmic solution and prednisolone acetate ophthalmic suspension) to R4's room. After applying gloves, ULP-B placed one drop of ketorolac to the left eye at 10:25 a.m. After 10 seconds (still 10:25 a.m.), ULP-B applied one drop of prednisolone to left eye. The surveyor did not observe ULP-B wait 5 minutes in between	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33260	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/12/2025
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01760	Continued From page 33 drops. ULP-B's training record included online medication overview training completed on November 17, 2024, but ULP-B's record lacked documentation of demonstrated competency on eye drop administration. The licensee's 7.34 Eye Drops and Eye Ointment policy dated July 2021, indicated ULP must be trained, and competency tested by a registered nurse. The procedure indicated if using more than one kind of eye drop, wait at least 1-2 minutes before using each type. INSULIN ADMINISTRATION R8 During observation on September 9, 2025, at 12:02 p.m., ULP-B set R8's Humalog insulin pen to 4 units, then within R8's room, did not clean abdomen prior with alcohol wipe before injecting insulin. ULP-B removed the insulin pen right away without keeping the needle under the skin for several seconds. The surveyor observed clear liquid (insulin) oozing out from the injection site. ULP-B's Injectable Diabetic Medication Competency dated July 1, 2025, indicated ULP-B was competent to perform insulin injections. The competency included instruction to keep the needle under the skin for a full count of 10 seconds to make sure the full dose is injected. Humalog "Instruction for Use" document last revised July 2023, instructed to insert the needle into the skin, push the dose knob all the way in, then continue to hold the dose knob in and slowly count to 5 before removing the needle. MEDICATION ADMINISTRATION	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33260	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/12/2025
NAME OF PROVIDER OR SUPPLIER SUITE LIVING SENIOR CARE OF VA			STREET ADDRESS, CITY, STATE, ZIP CODE 580 LIBERTY WAY VADNAIS HEIGHTS, MN 55127		
(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	
01760	Continued From page 34 DOCUMENTATION R10, R6, R2 R10 was admitted for assisted living services on February 14, 2024, and had diagnoses including atrial fibrillation (irregular heart rate). During observation on September 9, 2025, at 8:28 a.m., when surveyor arrived at medication cart, ULP-B was in the middle of setting up R14's medication. ULP-B then brought R14's medication to R14's room for administration. At 8:31 a.m., ULP-B arrived back to the medication cart, logged into R10's eMAR and stated, "I have already served [name of R10] in the morning," then proceeded to chart for the application of R10's lidocaine patch which was done during morning cares per ULP-B and documented oral medication was given. The surveyor was unable to observe what oral medications were given as ULP-B was clicking through the eMAR quickly. After that, ULP-B documented on R6's medications quickly so the surveyor was unable to observe what medications were being documented on. At 9:37 a.m., ULP-B began setting up R2's morning medications: acetaminophen (pain reliever), vitamin D3, magnesium oxide, omeprazole (acid reflux), vitamin B, Creon (digestive enzyme-was charted at this time even though it given earlier before breakfast), and midodrine (raises blood pressure). On September 10, 2025, at 3:08 p.m., CNS-A stated they needed a new routine to follow up on staff performance and make sure things are being done correctly. CNS-A stated he was not made aware of any concerns regarding ULP-B's medication administration. CNS-A explained staff were trained and deemed competent to administer medications.	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33260	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/12/2025
NAME OF PROVIDER OR SUPPLIER SUITE LIVING SENIOR CARE OF VA			STREET ADDRESS, CITY, STATE, ZIP CODE 580 LIBERTY WAY VADNAIS HEIGHTS, MN 55127		
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01760	Continued From page 35 The licensee's 7.08 Medication Management-Administration & Setup policy dated July 2021, indicated documentation of a medication reminder, medication assistance or medication administration will be completed immediately after that task has been performed. No further information was provided.	01760			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were secure and permitted access to only authorized personnel. 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 September 8, 2025, at 10:45 a.m., during the entrance conference, clinical nurse supervisor	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33260	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/12/2025
NAME OF PROVIDER OR SUPPLIER SUITE LIVING SENIOR CARE OF VA		STREET ADDRESS, CITY, STATE, ZIP CODE 580 LIBERTY WAY VADNAIS HEIGHTS, MN 55127			
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01880	Continued From page 36 (CNS)-A stated medications in both assisted living and memory care units were stored in two medication carts. CNS-A stated the licensee also had central storage of overstock or refrigerated medications within the nursing office. During observations on September 9, 2025, the surveyor noted the following: -at 8:15 a.m., entered the facility and observed a medication cart in the dining room area with the metal button popped out indicating it was unlocked. The surveyor went to another area of the facility to set up; -at 8:35 a.m., the surveyor noted a medication cup filled with milky pink substance sitting on top of the medication cart. Unlicensed personnel (ULP)-B pulled the key out of the metal button and left it unlocked, walked to R6's room. ULP-B returned to the medication cart at 8:37 a.m.; -at 8:40 a.m., after setting up R9's medications, R9 (sitting in his wheelchair next to the medication cart) pointed toward the floor near the medication cart wheel and ULP-B observed two pills (light pink ½ tablet, yellow oval tablet); -at 9:20 a.m., ULP-B stated the medication cup with pink liquid was cough medicine for another resident; -at 9:33 a.m., ULP-B took the key out of the button but did not lock it, then went to R11's room. Returned to medication cart at 9:35 a.m., no one was around at that time; -at 9:37 a.m., the surveyor noted two vials of albuterol nebulizer solution sitting on top of the medication cart near the pink liquid; -at 10:07 a.m., ULP-B brought R5's plastic medication box and one of the albuterol nebulizer vials and brought it to R5's room, gave him his oral medications, placed the plastic box (later identified to include diclofenac sodium cream, Deep Sea saline nose spray, polymyxin B Sulfate	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33260	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/12/2025
NAME OF PROVIDER OR SUPPLIER SUITE LIVING SENIOR CARE OF VA			STREET ADDRESS, CITY, STATE, ZIP CODE 580 LIBERTY WAY VADNAIS HEIGHTS, MN 55127		
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01880	Continued From page 37 eye drops, Systane eye drops, erythromycin ophthalmic ointment, and Breo Ellipta inhaler) on his table with the albuterol vial then left room. ULP-B did not stay to observe R5 administer oral medications or other medications brought in; -at 10:17 a.m., pink liquid medication and albuterol vial were still on top of the medication cart. ULP-B set up R5's morphine (opioid pain medication) and brought R4's eye drops and went to R4's room, placed the cup with morphine on R4's table near the surveyor and R4, then walked out of the room to obtain gloves and came back to administer R4's eye drops. ULP-B then brought the morphine to R5 for him to take; and -at 11:15 a.m., the surveyor observed the medication cart unlocked with key still attached unattended then saw ULP-B in the nursing office. Two people from a hospice (agency outside of licensee) sat down at the table next to the medication cart with R5. The medication cart was left unattended/unlocked until ULP-B returned at 11:26 a.m. On September 10, 2025, at 3:08 p.m., CNS-A stated the dropped yellow pill was pantoprazole and the ½ tablet was Synthroid (thyroid). CNS-A expected the medication cart to be secured when not in use and never walk away from medications leaving them unattended. The licensee's 7.11 Medication Storage policy dated July 2021, indicated when medications were managed and stored by licensee, medications would be kept securely locked and stored per manufacturer's directions. Only authorized staff would have access to stored medications. The policy also indicated medications would be stored consistent with each resident's medication management plan and service plan. Medications managed inside a	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33260	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/12/2025
NAME OF PROVIDER OR SUPPLIER SUITE LIVING SENIOR CARE OF VA		STREET ADDRESS, CITY, STATE, ZIP CODE 580 LIBERTY WAY VADNAIS HEIGHTS, MN 55127			
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01880	Continued From page 38 resident's private "living space" must be in securely locked and substantially constructed compartments and permit only authorized personnel to have access. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to dispose of medications upon expiration for one of three	01910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33260	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/12/2025
NAME OF PROVIDER OR SUPPLIER SUITE LIVING SENIOR CARE OF VA		STREET ADDRESS, CITY, STATE, ZIP CODE 580 LIBERTY WAY VADNAIS HEIGHTS, MN 55127			
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01910	Continued From page 39 residents (R7) receiving insulin administration assistance. 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: R7 had diagnoses including type two diabetes, generalized anxiety disorder, and presbyopia (loss of eye focus on nearby objects). R7's [licensee name] Assessment and ISP (individual service plan)-V3 dated June 15, 2025, assessed by clinical nurse supervisor (CNS)-A, indicating R7 required assistance with insulin and blood glucose management three times per day. R7's electronic medication administration record (eMAR) dated September 1-12, 2025, indicated Humalog Solution 100 unit/milliliters (ml) (fast-acting insulin), inject as per sliding scale within Humalog ranging between 1-5 units based on the blood glucose before meals three times per day. During observation on September 9, 2025, at 12:08 p.m., unlicensed personnel (ULP)-B was at the medication cart within the dining room area and pulled out the Humalog pen for R7. The surveyor positioned the pen while on the medication cart to be able to view the written open date of "6/17" and expired date of "7/15"	01910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33260	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/12/2025
NAME OF PROVIDER OR SUPPLIER SUITE LIVING SENIOR CARE OF VA			STREET ADDRESS, CITY, STATE, ZIP CODE 580 LIBERTY WAY VADNAIS HEIGHTS, MN 55127		
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01910	Continued From page 40 with initials "JK," and ULP-B noticed what the surveyor was doing so she looked at the date and said it was expired and needed to locate a different one. ULP-B searched the cart but was unable to locate another pen to use. ULP-B brought the expired pen to the nursing office and gave it to clinical nurse supervisor (CNS)-A then proceeded to the medication fridge and grabbed a new pen. ULP-B then went back to the medication cart and labeled it with an open date of that day's date then proceeded to finish the insulin administration. The surveyor asked ULP-B if the expired pen was used recently or over the weekend, ULP-B stated she did not work the weekend, so she did not know. The surveyor did not observe R7's morning insulin administration. It was unknown if the expired insulin was used. Humalog manufacturer instructions revised July 2023, indicated opened prefilled pens must be thrown away 28 days after first use, even if they still contained insulin. During interview on September 10, 2025, at 3:08 p.m., CNS-A expected the medication passers to be aware how critical those medications were and that it was paramount to give the correct dose and on time. CNS-A explained staff were trained and deemed competent to administer medications. If inconsistencies were discovered, they would investigate. The licensee's 7.03 Medication Management Individualized Plan policy dated July 2021, indicated a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions. No further information was provided.	01910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33260	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/12/2025
NAME OF PROVIDER OR SUPPLIER SUITE LIVING SENIOR CARE OF VA		STREET ADDRESS, CITY, STATE, ZIP CODE 580 LIBERTY WAY VADNAIS HEIGHTS, MN 55127			
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01910	Continued From page 41	01910			
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident specific documentation of the administration of a provided treatment was completed for one of one resident (R7) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33260	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/12/2025
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01960	Continued From page 42 R7 had diagnoses including type two diabetes, generalized anxiety disorder, and presbyopia (loss of eye focus on nearby objects). R7's [licensee name] Assessment and ISP (individual service plan)-V3 dated June 15, 2025, assessed by clinical nurse supervisor (CNS)-A, indicating R7 required assistance with the BiPAP (bilevel positive airway pressure for sleep apnea) using oxygen therapy. R7's electronic medication administration record (eMAR) dated September 1-11, 2025, indicated the following: -staff completed the task daily at 9:00 p.m., by initialing they assisted with the BiPAP using pressure 20/12 with two liters of oxygen at bedtime; and -weekly task of washing the BiPAP mask, nasal pillows, tubing and gray filter with soap and water, rinse let dry every Tues (initials on September 2 and 9). This task was put on hold on September 9, 2025, at 6:55 p.m. R7's progress notes dated August 29, 2025, at 11:06 a.m., licensed practical nurse (LPN)-J wrote a response from R7's primary clinic, indicating clinic staff would need to look into replacing the CPAP [sic] machine. During observation and interview on September 9, 2025, at 2:36 p.m., the surveyor observed R7 sitting in her recliner on a shelf next to R7's bed was the BiPAP machine with mask/tube. R7 explained she did not use her CPAP [sic] machine because it was broken. She indicated to get a new one, she would need to complete a sleep study which was scheduled that month. On September 10, 2025, at 3:15 p.m., R7 stated	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33260	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/12/2025
NAME OF PROVIDER OR SUPPLIER SUITE LIVING SENIOR CARE OF VA			STREET ADDRESS, CITY, STATE, ZIP CODE 580 LIBERTY WAY VADNAIS HEIGHTS, MN 55127		
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01960	Continued From page 43 staff had not touched the mask by cleaning it and that it had been broken for 3-4 years. During interview on September 9, 2025, at 3:30 p.m., CNS-A stated R7 had gone in phases when she wanted to use the BiPAP. R7's primary provider had been notified of the mask condition (falling apart requiring tape) and was informed R7 would need a sleep study before receiving a new one. CNS-A stated R7 is currently not using it. On September 10, 2025, at 3:30 p.m., CNS-A stated R7's mask was not in the best condition and had already communicated with her provider about obtaining a new one but would need to get a sleep study done first. At 1:08 p.m., CNS-A put BiPAP service on hold as of yesterday and stated R7 notified him she was not using it because it did not work properly and notified the provider on August 28, 2025. CNS-A stated he forgot to put the service on hold to keep the staff from documenting that service. R7's medical record lacked documentation explaining why the treatment was not performed. The licensee's 2.37 Resident Record-Documentation policy dated July 19, 2021, indicated when treatments not performed per the service agreement and schedule, staff must document the reason why it was not performed or administered, reported, and followed up on to meet the resident's needs. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33260	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/12/2025
NAME OF PROVIDER OR SUPPLIER SUITE LIVING SENIOR CARE OF VA		STREET ADDRESS, CITY, STATE, ZIP CODE 580 LIBERTY WAY VADNAIS HEIGHTS, MN 55127			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01970	Continued From page 44	01970			
01970 SS=F	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to obtain prescriber orders for all treatments and therapies, including the frequency, duration and other information needed to administer the treatment or therapy for one of one resident (R5) using compression stockings (TED hose). 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: R5 was admitted on July 10, 2019, under the licensee's comprehensive licensure and on August 1, 2021, began assisted living services. R5's [licensee] Service Agreement-V5 signed July 21, 2025, read R5 received assistance with "Ace	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33260	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/12/2025
NAME OF PROVIDER OR SUPPLIER SUITE LIVING SENIOR CARE OF VA			STREET ADDRESS, CITY, STATE, ZIP CODE 580 LIBERTY WAY VADNAIS HEIGHTS, MN 55127		
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01970	Continued From page 45 Wraps, TED hose, Surgical Stockings," per provider orders located on electronic medication administration record (eMAR). R5's [licensee] Assessment and ISP-V3 (nursing assessment) dated July 21, 2025, indicated R5 required TED hose treatment. R5's service task documentation dated September 1-11, 2025, noted staff initials once and/or twice daily indicating R5's TED hose was applied/removed. During observation on September 12, 2025, at 9:25 a.m., R5 was near the medication cart in the common area wearing shorts and applying creams to his knees. The surveyor observed what looked like black knee length compression stockings on both legs. On September 12, 2025, at 11:20 a.m., clinical nurse supervisor (CNS)-A located an old order for compression socks back in 2020, but his process of submitting annual orders was to print off the medication order summary and have the medical provider sign it. CNS-A was unsure if treatments were included in the medication order summary. CNS-A stated he would continue looking for a newer order in R5's medical record. On September 12, 2025, at 12:08 p.m., CNS-A provided R5's compression stocking order dated February 2, 2022. On September 12, 2025, at 1:05 p.m., CNS-A stated he did not have a current order for R5's compression stocking. CNS-A stated the medication order summary would not include treatments and therefore any treatments that were not listed on the eMAR, were not getting	01970			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER SUITE LIVING SENIOR CARE OF VA			STREET ADDRESS, CITY, STATE, ZIP CODE 580 LIBERTY WAY VADNAIS HEIGHTS, MN 55127		
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01970	Continued From page 46 renewed. CNS-A stated he would need change their process going forward to ensure both medication and treatment were getting renewed. The licensee's 7.18 Medications & Treatment Orders-Renewal policy dated July 20, 2021, indicated the licensee would have a current physician prescribed treatment order on record. Treatment orders must be renewed at least every 12 months or more frequently as required. A signed treatment order renewals would be placed in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970			
02310 SS=G	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 observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for one of one resident (R3) who utilized a portable side rail. 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	02310	During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33260	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/12/2025
NAME OF PROVIDER OR SUPPLIER SUITE LIVING SENIOR CARE OF VA			STREET ADDRESS, CITY, STATE, ZIP CODE 580 LIBERTY WAY VADNAIS HEIGHTS, MN 55127		
(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 47 than minimal harm to the resident) 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 observation and interview on September 8, 2025, at 3:15 p.m., the surveyor entered R3's room and noted R3 sitting in his manual wheelchair watching television. R3 was a right leg amputee and had a catheter leg bag attached to his left leg. The room was a studio that had a sitting chair next to a regular twin bed with two portable side rails - one on each side. The left side rail was positioned more toward the head of the bed and the right side rail was positioned more toward the center of the bed. The side rail was an elongated oval shape without any bars within the opening. The side rails were attached by straps that were wrapped around the padded frame of the bed and both side rails had two legs that extended from the base of the oval to the floor. The left side rail had one foot that was approximately one or two inches off the floor and did not touch the floor for stability. The side rails were black metal with one fourth of it padded with grey foam for hand comfort. When the surveyor grabbed onto the side rails, the side rails were able to pull out and shift side to side creating large gaps between the mattress and side rails. The left side rail dipped down when pressure was applied to the side rail by mimicking getting out of bed. The surveyor was unable to locate any information on the side rail itself to where it was made or any identifying information. R3 stated he used the left side rail to assist with getting in and out of bed. R3 did not respond when asked if he used the right side rail.	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33260	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/12/2025
NAME OF PROVIDER OR SUPPLIER SUITE LIVING SENIOR CARE OF VA			STREET ADDRESS, CITY, STATE, ZIP CODE 580 LIBERTY WAY VADNAIS HEIGHTS, MN 55127		
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02310	Continued From page 48 On September 8, 2025, at 3:53 p.m., clinical nurse supervisor (CNS)-A stated he reached out to R3's brother through electronic mail requesting the manufacturer's information, he did not receive a response. CNS-A knew the side rails were purchased by R3's brother on Amazon. CNS-A stated he was responsible for making sure side rails were installed correctly and he checked weekly to make sure side rails didn't pull away from the bed. CNS-A pulled on the side rail and it pulled out from under the mattress so he lifted the mattress up and observed the straps were interconnected with each other from each side rail. One of the metal joints was disconnected so CNS-A placed the metal parts together and it clicked back into place. CNS-A stated he did not install the side rails but he did check stability last week and did not recall the side rails to be this loose and did not notice that the footing was off the floor. CNS-A was unable to provide an answer when asked how he ensured they were installed correctly. CNS-A stated he would get in contact with R3's brother again to obtain the manufacturer's guideline. R3's Bed Rail (side rail) Assessment dated June 21, 2025, assessed R3 was non-ambulatory, had difficulty bearing weight, R3's awareness and understanding of his surroundings fluctuate, was moderately impaired cognitive status, had occasional unsafe behaviors (impulsive, self-transferred), had history of falls, displayed poor bed mobility, had difficulty with balance, requested to have side rails to promote safety and comfort, was educated on the risks versus benefits of using side rails, side rail model was NIMOOD C4 Pro, manufacturer's guidelines were obtained and have been installed according to those guidelines, had been inspected and were in	02310			

Minnesota Department of Health

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02310	Continued From page 49 good working order, and side rails were checked for recalls. On September 8, 2025, at 4:20 p.m., the surveyor asked CNS-A where he located the side rail name and model number, he stated he looked online for the closest one to R3's side rail and emailed R3's brother for the information but did not get a response so he used the information from online that looked most similar. CNS-A stated he had just spoke with R3's brother and was informed that the brother would check the Amazon order for the requested information. R3's signed [licensee name] Service Agreement-V5 dated March 21, 2025, indicated R3 received services including medication management and administration, bathroom assist, transfer assist, every two-hour safety checks, dressing and grooming, and catheter care. R3's Weekly Bed Rail [side rail] Inspection/Assessment dated September 4, 2025, completed by CNS-A, indicated R3 had consumer side rails, the manufacturer's guidelines were filed in the side rail assessment binder (though not for R3's actual side rails), inspection of the side rail was completed, and the side rails were in good working order. R3's medical record lacked documentation of the following: -physical inspection of side rails and mattress for areas of entrapment, stability, and correct installation; -portable side rails had not been recalled by the Consumer Product Safety Commission (CPSC); and -portable side rails were installed, used, and	02310			

Minnesota Department of Health

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02310	Continued From page 50 maintained per manufacturer's guidelines. On September 9, 2025, at 10:27 a.m., CNS-A provided the surveyor with R3's side rail make, model (Sangohe Duty Bed Rail-foldable bed assist handle-504E), and installation instructions. CNS-A stated he attempted to tighten the side rails and showed the surveyor the side rails. On September 10, 2025, at 9:00 a.m., regional director of operations (RDO)-E and regional director of nursing (RDON)-F stated nursing staff were not allowed to install any side rail but were able to tighten them when necessary. RDO-E and RDON-F acknowledged R3's record lacked manufacturer's guidelines and that checking for recalls could not be done without that information. RDON-F stated nursing staff were responsible for completing the weekly side rail inspection and completing side rail assessments. The licensee's 6.28 Side Rails policy revised May 10, 2023, indicated licensed staff would inspect and assess side rails weekly, check for recalls on consumer side rails, and check to make sure the side rail is in good working order and the nurse would tighten the side rail as tightly as possible. The side rail binder included manufacturer's guidelines for type of bed and type of side rail. Rails must be compatible with the bed. The Minnesota Department of Health (MDH) website, 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	02310			

Minnesota Department of Health

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02310	Continued From page 51 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." In addition, the MDH website indicated, "licensees should refer to the CSPC for the most up-to-date information related to portable bed side rail recall information." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310			
02320 SS=D	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	02320			

Minnesota Department of Health

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02320	Continued From page 52 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 unlicensed personnel (ULP)-B followed appropriate medication administration procedures for one of one resident (R2) while administering 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 had diagnoses including type 1 diabetes, chronic atrial fibrillation, hypertension, and transient cerebral ischemic attack (stroke). R2's signed [licensee name] Service Agreement dated May 30, 2025, indicated R2 received assistance with medication administration and blood glucose checks. R2's electronic medication administration record (eMAR) dated September 1-9, 2025, indicated the following: -Creon oral capsule delayed release particles 24000-76000 unit-give two capsules by mouth	02320			

Minnesota Department of Health

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02320	Continued From page 53 three times a day before each meal; and -Administer Novolog Flex Pen 100 unit/milliliter (ml), inject as per sliding scale-if blood glucose (BG) is 70-199, give 1 unit, 200-249, give 4 units, 250-299, give 5 units, 300-349, give 6 units, 350-399, give 7 units, 400-600, give 8 units and call nurse/doctor, subcutaneously three times a day. R2's provider orders dated May 1, 2025, indicated by the provider glucose results were reviewed and ordered to change mealtime Novolog insulin to: -give at meals three times daily. For blood glucose (BG) less than 70, refer to Hypoglycemia Treatment Protocol. For BG 70-199, give two units. For BG 200-249, give 4 units. For BG 250-299, give 5 units. For BG 300-349, give 6 units. For BG 350-399, give 7 units. For BG 400 or greater, give 8 units. R2's provider order dated July 1, 2025, ordered Creon 24,000-76,000-120,000 unit capsule (digestive enzyme)-give two capsules by mouth three times daily. During observation on September 9, 2025, at 11:40 a.m., R2 was at the dining room table near the medication cart within the smaller dining room. ULP-B checked R2's blood glucose using a lancet (needle) to right middle finger. BG was 457, and ULP-B administered 8 units of Novolog insulin. Without looking at the eMAR, ULP-B pulled a bottle from the medication cart and poured two capsules from the bottle into a medication cup and administered to R2. The surveyor was able to observe the bottle labeled "Creon" but did not observe ULP-B check the eMAR to confirm the "6 rights" of medication administration (right person, right medication,	02320			

Minnesota Department of Health

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02320	Continued From page 54 right time, right route, right dose, and right chart/record to document the administration). ULP-B proceeded to check BG's and administer insulin for three residents thereafter without notifying a nurse of R2's high BG result. ULP-B's training record included online medication overview training completed on November 17, 2024, but ULP-B's record lacked documentation of demonstrated competency on oral medication administration. ULP-B's Glucose Testing competency dated October 5, 2017, indicated ULP-B was competent to complete glucose testing. During interview on September 10, 2025, at 3:08 p.m., clinical nurse supervisor (CNS)-A stated he expected ULP's who administered medication know how important it was to make sure residents receive the correct dose, at the correct time, and etc. He stated he observed staff performing tasks within 30 days of performing a task then if he was made aware of any inconsistencies, then that would trigger him to investigate. CNS-A stated he was not made aware of any issues prior to the survey. At 3:15 p.m., CNS-A stated he was not notified by ULP-B of R2's high blood glucose. He stated staff had notified him in the past and sometimes staff used "Teams" to notify him but "I should be better about making sure staff notify me," and stated R2's record lacked documentation showing staff had been notifying a nurse. The licensee's 7.03 Medication Management Individualized Plan dated July 2021, indicated residents receiving medication management services, the licensee would include procedures for staff notifying a registered nurse or	02320			

Minnesota Department of Health

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02320	Continued From page 55 appropriate licensed health professional when a problem arises with medication management services. The licensee's 7.15 Medication & Treatment-Administration & Delegation policy dated July 2021, indicated when administration of medications or treatment/therapy are delegated or assigned to unlicensed personnel, licensee would ensure the registered nurse has instructed the ULP in proper methods with respect to each resident to administer the medications or perform treatment/therapy, and the ULP has demonstrated the ability to competently follow the procedures. 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

Page: 1

Establishment Info

SUITE LIVING SENIOR CARE OF VA
580 LIBERTY WAY
Vadnais Heights, MN 55127
Ramsey County
Parcel:

Phone:

License Info

License: HFID 33260

Risk:
License:
Expires on:
CFPM: TAMMY J. BATES
CFPM #: FM116276; Exp: 04/06/2026

Inspection Info

Report Number: F1005251121
Inspection Type: Full - Single
Date: 9/9/2025 Time: 10:00 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

INSPECTION COMPLETED WITH KITCHEN MANAGER AND REVIEWED WITH HRD NURSING EVALUATOR ANNA BOHNEN.

REVIEWED SYMPTOMS OF FOODBORNE ILLNESSES AND THE REQUIREMENT TO MAINTAIN AN EMPLOYEE ILLNESS LOG OF THOSE INSTANCES WHEN EMPLOYEES ARE ILL WITH VOMITING OR DIARRHEA "AND" IMMEDIATELY EXCLUDE FROM THE FOOD ESTABLISHMENT ANY FOOD EMPLOYEE ILL WITH VOMITING OR DIARRHEA. EMPLOYEES MUST BE EXCLUDED FOR AT LEAST 24 HOURS AFTER LAST SYMPTOM.

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 F1005251121 from 9/9/2025

TAMMY BATES
KITCHEN MANAGER

Jessica Davis, REHS
Public Health Sanitarian 3
651-201-3961
jessica.davis@state.mn.us



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

Temperature Observations/Recordings

Page: 1

Establishment Info

SUITE LIVING SENIOR CARE OF VA
Vadnais Heights
County/Group: Ramsey County

Inspection Info

Report Number: F1005251121
Inspection Type: Full
Date: 9/9/2025
Time: 10:00 AM

Food Temperature: **Product/Item/Unit:** HARD BOILED EGG; **Temperature Process:** Cold-Holding

Location: NORLAKE COOLER 1 at 38 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** MILK; **Temperature Process:** Cold-Holding

Location: NORLAKE COOLER 1 at 40 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** CHOW MEIN; **Temperature Process:** Cold-Holding

Location: NORLAKE COOLER 2 at 38 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** HAM; **Temperature Process:** Cold-Holding

Location: NORLAKE COOLER 2 at 40 Degrees F.

Comment:

Violation Issued?: No



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

Sanitizer Observations/Recordings

Page: 1

Establishment Info

SUITE LIVING SENIOR CARE OF VA
Vadnais Heights
County/Group: Ramsey County

Inspection Info

Report Number: F1005251121
Inspection Type: Full
Date: 9/9/2025
Time: 10:00 AM

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine

Location: Equal To 165 Degrees F.

Comment:

Violation Issued?: No

Sanitizing Chemical: Product: LACTIC ACID; **Sanitizing Process:** Wiping Cloth Bucket

Location: Equal To 704 PPM

Comment:

Violation Issued?: No

Sanitizing Chemical: Product: LACTIC ACID; **Sanitizing Process:** Dispenser

Location: 3-Comp Sink Greater Than 704 PPM

Comment:

Violation Issued?: No