Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 29, 2026

Licensee
Suite Living Senior Care of Prior Lake LLC
5600 Credit River Road Southeast
White Bear Lake, MN 55110

RE: Project Number(s) SL39149016

Dear Licensee:

On April 14, 2026, 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 January 29, 2026. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the January 29, 2026 survey.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on January 29, 2026, found not corrected at the time of the April 14, 2026, follow-up survey and/or subject to penalty assessment are as follows:

1640-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (a-E) - $500.00
1650-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (f) - $500.00
1890-Prescription Drugs-144g.71 Subd. 20 - $500.00

The details of the violations noted at the time of this follow-up survey completed on April 14, 2026 (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 $1,500.00**. 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 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 Jodi Johnson at 507-344-2730.

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,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39149	A. BUILDING: _____ B. WING _____	R 04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SENIOR CARE OF PRIOR LAKE	5600 CREDIT RIVER ROAD SE WHITE BEAR LAKE, MN 55110

(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 SL39149016-1 On April 13, 2026, through April 14, 2026, , 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 January 29, 2026. At the time of the survey, there were 28 residents; 28 receiving services under the Assisted Living with Dementia Care license. As a result of the follow-up survey, the following orders were reissued: 1640, 1650, 1890.	{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.	
{01640} SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	{01640}		

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{01640}	Continued From page 1 (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the written service plan was followed related to feeding assistance for one of one resident (R8) requiring assistance with eating. 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).	{01640}		

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{01640}	Continued From page 2 The findings include: R8's diagnoses included dementia and congestive heart failure. R8's Service Agreement effective December 19, 2025, indicated R8 required assistance with dressing, grooming, toileting, bathing, ambulation, transfers with two staff utilizing a Hoyer lift, repositioning, medication administration, meals, laundry, and housekeeping. R8's Service Plan Report dated March 11, 2026, indicated: Assistance with feeding - sit with resident during meal and feed. Care staff will report any changes in ability to eat or drink. R8's untitled, services record dated April 2026, indicated: FEEDING: Place bib on resident. Sit with her and assist with feeding-encourage her to do as much as she can. Stay with her until finished. On April 14, 2026, at 8:11 a.m., the surveyor observed R8 seated in a Broda chair being wheeled out of her room to the dining room by unlicensed personnel (ULP)-H. On April 14, 2026, during continuous observation from 8:36 a.m., until 9:37 a.m., the surveyor observed the following: - 8:36 a.m. - R8 was seated in a Broda chair at a table in the secure memory care dining room; no other residents were seated at the table with R8. R8 had a bowl of oatmeal and an empty glass in front of her. R8 was holding a spoon and using it to move the oatmeal around in the bowl; she did not attempt to bring the food to her mouth. ULP-E was setting up medications at the	{01640}		

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{01640}	Continued From page 3 medication cart located near (within eyesight of) the dining room; activity director (AD)-L was seated at a different table in the dining room talking to another resident. - 8:52 a.m. - R8 continues to either stir the oatmeal or tap the spoon on the side of the bowl; R8 has still not taken a bite of the food. No staff are in the dining room at this time. The surveyor observed the amount of oatmeal in the bowl, which was half to three-quarters full. - 8:56 a.m. - R8 removed the spoon from the bowl and placed on top of the placemat while still holding onto the spoon. There was some food on the spoon but R8 did not attempt to eat it. - 8:59 a.m. - R8 released spoon from her hand, spoon remains on the placemat near the bowl, resident has eyes closed. - 9:05 a.m. - R8 continues to sit at the table with the oatmeal in front of her but not eating. At this time, ULP-E is back at the medication cart near the dining area; ULP-J was observed circulating between the dining room and through the door to the kitchen, and ULP-H also entered the dining area. A different female resident had come into the dining room in the mean time and sat down at the same table as R8. ULP-H approached the new resident and asked her what she would like for breakfast, then proceeded to obtain fluids for that resident, then went into the kitchen to prepare the resident's breakfast. - 9:15 a.m. ULP-H brought the breakfast meal to the other female resident sitting at R8's table. ULP-J continues to circulate throughout the dining area and in and out of the kitchen. No one has approached R8 who still has not attempted to eat her breakfast. - 9:16 a.m. - ULP-H approached R8 at this time. ULP-H picked up R8's bowl of oatmeal, spoon, and empty glass and placed it on a cart near the sink in the dining area. ULP-H then obtained a	{01640}		

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{01640}	Continued From page 4 wet wipe and cleaned R8's face. - 9:20 a.m. - Clinical nurse supervisor (CNS)-B entered the secure memory care unit at this time. CNS-B stated staff are to assist R8 with eating, although they should encourage R8 to do as much as she can for herself. CNS-B further stated staff are expected to stay with R8 throughout the meal and assist as needed. The surveyor shared her dining observation of R8 with CNS-B. CNS-B then prompted ULP-H and ULP-J to join her in the kitchen. Shortly thereafter, ULP-H came out of the kitchen with a bowl of oatmeal and heated it in the microwave. ULP-H then proceeded to feed R8 the oatmeal which the resident accepted. At 9:37 a.m., ULP-H finished feeding R8 her oatmeal and transported the resident to her room. On April 14, 2026, at 9:39 a.m., ULP-H stated when R8 initially received her breakfast, ULP-H had fed the resident "a few bites" before leaving R8 to finish on her own. ULP-H further stated when she came back to assist R8, she obtained a new bowl of oatmeal and R8 consumed most of it. No further information was provided.	{01640}		
{01650} SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff	{01650}		

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{01650}	Continued From page 5 who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of two residents' (R1, R2) service plans included all the required content. 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 is 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).	{01650}		

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{01650}	Continued From page 6 The findings include: R1 R1's diagnoses included spinal stenosis, congestive heart failure, atrial fibrillation, and type II diabetes. R1's Service Agreement signed February 11, 2025, indicated R1 received services including assistance with dressing, grooming, toileting, bathing, ambulation, transfers with two staff utilizing a Hoyer lift, catheter care, CPAP (continuous positive air pressure) machine, wound care, repositioning, medication administration, meals, housekeeping, and laundry. R1's service plan lacked the following content: - the schedule and methods of monitoring staff providing services R2 R2's diagnoses included type II diabetes mellitus, atrial fibrillation, and chronic kidney disease. R2's Service Agreement dated December 18, 2025, indicated R2 received services including assistance with dressing, grooming, bathing, toileting, transfers, ambulation, repositioning, medication administration, meals, housekeeping, and laundry. R2's service plan lacked the following content: - the schedule and methods of monitoring staff providing services On January 28, 2026, at 10:24 a.m., regional director of nursing (RDON)-C stated the service plan format utilized for all residents included that the RN supervises staff at least every 90 days.	{01650}		

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{01650}	Continued From page 7 RDON-C further stated although new direct care staff were supervised performing delegated tasks within 30 days of hire by an RN as required, this was not included in any of the resident service plans. During the entrance conference for the revisit survey on April 13, 2026, at 12:07 p.m., licensed assisted living director (LALD)-A reviewed the licensee's plan of correction. LALD-A stated the verbiage for the 30-day supervision of new hires providing delegated nursing services had not been added to the resident service plans as this was part of the "agreement". LALD-A stated she was not sure if the "agreement" meant it was part of the contract or not. LALD-A stated she would check with RDON-C and get back to the surveyor. On April 13, 2026, at 1:06 p.m., RDON-C stated she had discussed with management the need to add the verbiage for the 30-day supervision for new hires providing direct care delegated nursing services. RDON-C and management had reviewed the statute; since it didn't specifically indicate this verbiage was necessary, they had decided their existing service plan was sufficient and within regulation requirements. RDON-C stated she will investigate further to see if they have the 30-day supervision verbiage elsewhere that all residents receive upon admission. The licensee's 6.08 Service Plan policy dated August 1, 2022, indicated: 9. A service plan will include: f. A schedule and method for the next planned monitoring of staff providing services. No further information was provided.	{01650}		

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{01890}	Continued From page 8	{01890}		
{01890} SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescription medications were kept in the original container bearing the original prescription label for one of four residents (R9) who received insulin. 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: R9's diagnoses included type II diabetes mellitus. R9's Service Agreement effective March 2, 2026, indicated R9's services included medication administration. R9's medication administration record (MAR) dated April 2026, included the following order: insulin aspart subcutaneous solution pen-injector	{01890}		

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{01890}	Continued From page 9 100 unit/milliter. Inject as per sliding scale: - 201-250 = 2 units - 251-300 = 3 units - 301-350 = 4 units - 351-400 = 5 units - 401-500 = 6 units subcutaneously before meals related to type 2 diabetes mellitus. Do not give if resident is not eating. On April 14, 2026, at 10:49 a.m., the surveyor observed resident insulin pens stored in the assisted living medication cart, with unlicensed personnel (ULP)-I. R9's Novolog (insulin aspart) insulin pen had a pharmacy label attached to the pen that was incomplete. The insulin pen included resident's name, name of medication, and the following sliding scale amounts: 301-350 = 6 units; 351-400 = 8 units; > (greater than) 400 = 10 units. ULP-I stated the prescription was incomplete and would notify the nurse. In addition to the label being incomplete, it was also not the current sliding scale order. On April 14, 2026, at 11:35 a.m., clinical nurse supervisor (CNS)-B stated she has had conversations with the pharmacy about providing full prescription labels for residents with sliding scale insulin; however, they did not receive one for R9. The licensees's 7.13 Medications-Prescription Drugs & Prohibition policy dated July 21, 2021, indicated: When Suite Living receives a prescription dug, prior to being set up for immediate or later administration, the prescription drug must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or	{01890}		

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{01890}	Continued From page 10 beyond-use date of a time-dated drug. No further information was provided.	{01890}		

Electronically Delivered

February 13, 2026

Licensee
Suite Living Senior Care Of Prior Lake LLC
5600 Credit River Road Southeast
White Bear Lake, MN 55110

RE: Project Number(s) SL39149016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 29, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

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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:

1640 - 144g.70 Subd. 4 (a-E) - Service Plan, Implementation And Revisions To - $1,000.00
2320 - 144g.91 Subd. 4 (b) - 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 $2,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39149	A. BUILDING: _____ B. WING _____	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SENIOR CARE OF PRIOR LAKE	5600 CREDIT RIVER ROAD SE WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL39149016-0 On January 26, 2026, through January 29, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 28 residents; 28 receiving services under the Assisted Living Facility with Dementia Care license. 1640: On January 28, 2026, an immediate order was issued at a level 3/Isolated (G). The licensee took action to mitigate risk; however, scope and level remain at G. 2320: On January 28, 2026, an immediate order was issued at a level 3/Isolated (G). The licensee took action to mitigate risk; however, scope and level remain at G.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 550	Continued From page 1	0 550		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is 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	0 550		

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0 550	Continued From page 2 portion or all of the residents). The findings include: On January 26, 2026, at 2:01 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. There were postings by the front entrance that included the grievance procedure but did not include contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. At that time, LALD-A confirmed the content noted above was not posted as required. The licensee's 2.10 Complaint/Grievance Posting policy dated July 19, 2021, indicated: 1. Suite Living will post, in a conspicuous place, information about our complaint/grievance procedure, and the name, telephone number, and email contact information for the individual(s) who are responsible for handling resident complaint/grievances. 2. The posting will also have the contact information for the Office of Ombudsman for Long Term Care and the Ombudsman for Mental Health and Developmental Disabilities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent	01060		

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01060	Continued From page 3 risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and	01060		

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01060	Continued From page 4 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included spinal stenosis, congestive heart failure, atrial fibrillation, and type II diabetes. R1's Service Agreement signed February 11, 2025, indicated R1 required assistance with dressing, grooming, toileting, bathing, ambulation, transfers with two staff utilizing a Hoyer lift, catheter care, CPAP (continuous positive air pressure) machine, wound care, repositioning, medication administration, meals, and housekeeping. R1's progress notes revealed the resident had been hospitalized on October 16, 2025, due to excessive bleeding from his left great toe wound. The progress notes further indicated R1 returned to the licensee on October 20, 2025. On January 28, 2026, at 10:24 a.m., clinical nurse	01060		

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01060	Continued From page 5 supervisor (CNS)-B reviewed R1's record and could not locate evidence the written notice of emergency relocation had been provided to R1 or R1's representative as required. The licensee's 1.23 Emergency Relocation policy dated August 1, 2022, indicated: 1. In the event of an emergency relocation, Suite Living will provide a written notice that contains, at a minimum: a. The reason for the relocation b. The name and contact information for the location to which the resident has been relocated and any new service provider c. Contact information for the Office of Ombudsman for Long-Term Care and Office of Ombudsman for Mental Health and Developmental Disabilities d. If known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known, and e. A statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal. 3. The facility will provide contact information for the agency to which the resident may submit an appeal. 4. The notice required will be delivered as soon as practicable to: a. The resident, legal representative, and designated representative b. For residents who receive home and community-based waiver services, the resident's case manage, and c. The Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. No further information was provided.	01060		

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01060	Continued From page 6 TIME PERIOD TO CORRECT: Twenty-one (21) days	01060		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living	01620		

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01620	Continued From page 7 services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a resident assessment within 14 days of admission for one of one new resident (R1) and ongoing resident reassessments that did not exceed 90 days for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1	01620		

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01620	Continued From page 8 R1 began receiving services on February 11, 2025, with diagnoses including spinal stenosis, congestive heart failure, atrial fibrillation, and type II diabetes. R1's Service Agreement signed February 11, 2025, indicated R1 received services including assistance with dressing, grooming, toileting, bathing, ambulation, transfers with two staff utilizing a Hoyer lift, catheter care, CPAP (continuous positive air pressure) machine, wound care, repositioning, medication administration, meals, housekeeping, and laundry. R1's record included an admission assessment dated February 11, 2025, and a 14-day assessment dated February 26, 2025, (one day late). On January 28, 2026, at 10:24 a.m., clinical nurse supervisor (CNS)-B reviewed R1's assessments and stated R1's 14-day assessment was completed late. R2 R2 began receiving services on November 20, 2023, with diagnoses including type II diabetes mellitus, atrial fibrillation, and chronic kidney disease. R2's Service Agreement dated December 18, 2025, indicated R2 received services including assistance with dressing, grooming, bathing, toileting, transfers, ambulation, repositioning, medication administration, meals, housekeeping, and laundry. R2's last three assessments were requested. Assessments dated June 11, 2025, September	01620		

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01620	Continued From page 9 10, 2025, and December 18, 2025, were provided. 91 days had passed between the June to September assessments (one day late), and 100 days had passed between the September to December assessments (10 days late). On January 29, 2026, at 12:40 p.m., CNS-B reviewed R2's assessments and stated the last two 90-day assessments had been completed late. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated August 1, 2022, indicated: 3. Resident assessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=G	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident	01640		

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01640	Continued From page 10 about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed ensure the written service plan was followed related to repositioning for one of one dependent resident (R1) at risk for skin breakdown. This resulted in an immediate correction order issued January 28, 2026, at approximately 1:30 p.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included spinal stenosis, congestive heart failure, atrial fibrillation, and type	01640		

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01640	Continued From page 11 II diabetes. R1's Service Agreement signed February 11, 2025, indicated R1 required assistance with dressing, grooming, toileting, bathing, ambulation, transfers with two staff utilizing a Hoyer lift, catheter care, CPAP (continuous positive air pressure) machine, wound care, repositioning, medication administration, meals, and housekeeping. R1's Service Plan Report dated January 9, 2026, indicated: Staff will notify RN immediately if fragile skin or breakdown is present. Observe for and report to the nurse any complaints of pain and/or requests for pain medications. Care staff will report any new complaints of pain. R1's untitled services record dated January 2026, indicated: - Resident needs to be transferred out of his w/c (wheelchair) after meals and put into bed or recliner to prevent pressure sores. - Repositioning Q2h (every two hours) R1's admission skin observation assessment dated February 11, 2025, indicated R1 had an unstageable right heel pressure ulcer measuring 8 cm (centimeters) in length, and 5 cm in width. The assessment further indicated R1 had redness to his coccyx. R1's recent assessment dated January 6, 2026, indicated staff apply Triad paste to buttocks daily with brief changes. R1's provider orders dated November 5, 2025, included: Triad hydrophilic wound dress external paste. Apply to buttocks wounds topically two times a day for wound care. Apply a thin layer.	01640		

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01640	Continued From page 12 On January 26, 2026, at 4:13 a.m., the surveyor observed R1 seated in his recliner lift chair in his room with a Hoyer lift sheet underneath him. The lift chair was in what appeared to be the highest position. The surveyor greeted R1 and made a comment about the chair being up so high and feared he may fall out of it. R1 lowered the chair and stated " my butt is killing me" and it felt better when he was in this position. The surveyor asked R1 if he had any sores on his bottom and he stated, "yes". On January 27, 2026, at 8:12 a.m., the surveyor observed unlicensed personnel (ULP)-D administering medications to R1 in his room; R1 was lying on his back in bed watching television. Following the observation, the surveyor asked ULP-D if R1 had any sores on his bottom that they were treating. ULP-D stated R1 had some redness on his bottom and they apply a paste to it when they change him before getting him up for the day. ULP-D stated the paste is kind of "caked" on and difficult to remove when cleansing the area prior to reapplying. ULP-D further stated feeling bad when she cleanses the area as R1 will flinch like it hurts. ULP-D stated she hadn't observed the area for a few days and was unsure if the nurses were aware of it. The surveyor asked what time R1 gets up out of bed and ready for the day; she stated usually around 10:00 a.m., at which time they will transfer him to his recliner. On January 27, 2026, at 10:05 a.m., the surveyor observed ULP-D and ULP-E providing morning (AM) cares for R1. Prior to the ULPs performing the cares, the surveyor asked R1 if staff were repositioning him in his bed or in his chair and he stated "no." The surveyor further asked R1 if he would be agreeable to being repositioned from	01640		

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01640	Continued From page 13 side to side to get the pressure off his bottom and he stated "yes." The surveyor then asked ULP-E if staff reposition R1 when in bed; ULP-E stated they don't reposition him in bed, "He always lies on his back." ULP-E further stated after breakfast and AM cares, they transfer him (R1) into his recliner and he's still there when they leave for the day (2:00 p.m.) ULP-D and ULP-E proceeded to perform care for R1 including emptying his catheter bag and applying a new bag. The ULPs then removed R1's brief, ULP-E provided peri-care for R1, then ULPs rolled R1 onto his right side to cleanse his bottom before applying the Triad wound paste. R1's bottom was observed to be extremely reddened surrounding right and left gluteal clefts and buttocks. An open area was observed near the left gluteal crease that was approximately 2.5 cm in width. The surveyor asked ULP-D if the open area was present the last time she worked with R1, and she stated it wasn't. ULP-D further stated they looked worse - more red and sore. ULP-D continued to assist holding R1 on his side while ULP-E cleansed R1's affected area on the buttocks and did not make any attempt to contact nursing. At this time, the surveyor indicated to the ULPs that a nurse needed to observe the area, and exited the room to find a nurse. The surveyor informed regional director of nursing (RDON)-C of R1's open wound. The surveyor and RDON-C then returned to R1's room and RDON-C then took over completion of the wound treatment, including assessing and measuring the wound. RDON-C stated the redness to R1's bottom was not a new finding, and that they have documentation on it. Per RDON-C's measurements; R1's left gluteal had blanchable redness measuring 9.5 cm x 9 cm; open wound in center measuring 2.5 cm x 2 cm. R1's right gluteal was blanchable and measured 10.5 cm x	01640		

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01640	Continued From page 14 6 cm, wound in center measuring 4 cm x 0.5 cm; is stage 1 - red/purple in color and shaped like a straight line. RDON-C asked R1 if he was having any pain on his bottom. R1 stated he was and rated the pain 4-5 out of 10. RDON-C then directed ULP-D to administer PRN (as needed) Tylenol if available. Once RDON-C had completed the treatment and assisted staff with applying a clean brief for R1, the ULPs then finished AM cares for R1 and transferred him into his recliner with the Hoyer lift. On January 27, 2026, at 1:03 p.m., ULP-D and ULP-E stated they don't reposition R1 as it was not included in his care plan. The ULPs stated they get him (R1) out of bed at 10:00 a.m. and transfer him to his recliner. He can then position his recliner on his own, but they do not assist with repositioning. ULP-D further stated the evening shift puts R1 back in his bed; probably after supper. Review of R1's untitled services record dated January 2026, indicated ULP-D had charted repositioning R1 on the following days: January 3, 2026 - three times January 6, 2026 - four times January 15, 2026 - three times January 17, 2026 - one time January 20, 2026 - four times ULP-E charted repositioning R1 on January 1, 2026, one time. On January 27, 2026, at 1:18 p.m., clinical nurse supervisor (CNS)-B stated R1 was to be repositioned and off-loaded every two hours. CNS-B stated this would be completed by using pillows to help him reposition from side to side. CNS-B stated it is in his care plan to reposition and was unaware ULP-D and ULP-E were not	01640		

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01640	Continued From page 15 completing this. CNS-B was also unaware the redness on R1's bottom had worsened as this wasn't an area she was monitoring weekly. On January 27, 2026, at 1:46 p.m., R1 stated once he gets up for the day, he stays in his recliner until he goes to bed for the night; usually until about 5:30 or 6:30 p.m. R1 stated neither the day or the evening shift try to reposition him in his chair, but he doesn't ask them to. R1 stated if they wanted to do that it would be ok with him. R1 further stated they don't reposition him in bed either, "It doesn't hurt when I'm in bed". R1 further stated he changes his position in his recliner from sitting up to lying back. The surveyor asked if that helped relieve the pressure, he stated "there is a spot farther back that is sore" and if he changes position, it "helps the pain" and it "feels a lot better." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On January 29, 2026, the facility implemented corrective actions to address this issue. The scope and severity remains at G.	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services;	01650		

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01650	Continued From page 16 (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two residents' (R1, R2) service plans included all the required content. 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 is 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:	01650		

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01650	Continued From page 17 R1 On January 26, 2026, at 4:13 p.m., the surveyor observed R1 seated in a lift recliner in his room with blue heel boots on his feet bilaterally. R1's diagnoses included spinal stenosis, congestive heart failure, atrial fibrillation, and type II diabetes. R1's Service Agreement signed February 11, 2025, indicated R1 received services including assistance with dressing, grooming, toileting, bathing, ambulation, transfers with two staff utilizing a Hoyer lift, catheter care, CPAP (continuous positive air pressure) machine, wound care, repositioning, medication administration, meals, housekeeping, and laundry. R1's medication administration record (MAR) dated January 2026, indicated the following: - Boots on while in bed or float heels on pillows. Every shift for heel ulcer R1's service plan lacked the following content: - the schedule and methods of monitoring staff providing services - assistance with heel boots R2 R2's diagnoses included type II diabetes mellitus, atrial fibrillation, and chronic kidney disease. R2's Service Agreement dated December 18, 2025, indicated R2 received services including assistance with dressing, grooming, bathing, toileting, transfers, ambulation, repositioning, medication administration, meals, housekeeping, and laundry.	01650		

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01650	Continued From page 18 R2's service plan lacked the following content: - the schedule and methods of monitoring staff providing services On January 28, 2026, at 10:24 a.m., clinical nurse supervisor stated R1's heel boots were not included on his service plan though staff were charting the service was being completed. Regional director of nursing (RDON)-C stated the service plan format utilized for all residents included that the RN supervises staff at least every 90 days. RDON-C further stated though new direct care staff were supervised performing delegated tasks within 30 days of hire by an RN as required, this was not included in any of the resident service plans. The licensee's 6.08 Service Plan policy dated August 1, 2022, indicated: 9. A service plan will include: a. A description of the services that are to be provided based on the most recent assessment and resident preferences f. A schedule and method for the next planned monitoring of staff providing services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the	01890		

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01890	Continued From page 19 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 prescription medications were kept in the original container bearing the original prescription label for one of one resident (R4) during insulin 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4's diagnoses included type II diabetes mellitus. R4's Service Plan dated June 12, 2025, indicated R4's services included medication administration. R4's medication administration record (MAR) dated January 2026, included the following order: insulin aspart subcutaneous solution pen-injector 100 unit/milliter Inject as per sliding scale: - 71-140 = 0 units - 141-180 = 2 units - 181-220 = 4 units - 221-260 = 6 units - 261-300 = 8 units - 301-350 = 10 units - 351-400 = 12 units - 401+ = 14 units. If over 400, give 14 units and	01890		

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01890	Continued From page 20 contact the nurse, subcutaneously before meals. On January 27, 2026, at 11:32 a.m., the surveyor observed unlicensed personnel (ULP)-F preparing R4's Novolog (insulin aspart) pen for administration. The pharmacy label attached to the insulin pen was incomplete; it included the resident's name, name of medication, and the following sliding scale amounts: 181-220 = 4 units; 221-260 = 6 units; 261-300 = 8 units *more. ULP-F reviewed the pharmacy label on R4's insulin pen and stated it was incomplete. ULP-F also looked inside the medication cart to see if a complete label was present and was unable to locate one. On January 29, 2026, at 12:51 p.m., clinical nurse supervisor (CNS)-B observed R4's open Novolog insulin pen located in the medication cart. CNS-B stated the pharmacy label on the pen did not include the entire order as required. The licensees's 7.13 Medications-Prescription Drugs & Prohibition policy dated July 21, 2021, indicated: When Suite Living receives a prescription dug, prior to being set up for immediate or later administration, the prescription drug must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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01940	Continued From page 21	01940		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of two	01940		

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01940	Continued From page 22 residents (R1). 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 the entrance conference on January 26, 2026, at 1:06 p.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatment management services to residents, including assistance with CPAP (continuous positive airway pressure) machines. On January 26, 2026, at 4:13 p.m., the surveyor observed R1 seated in a recliner in his room. The surveyor noted a CPAP machine on the bedside near the head of R1's bed. R1 stated he used the CPAP machine during the night while sleeping. R1's Service Agreement signed February 11, 2025, indicated R1 received services including assistance with a CPAP (continuous positive air pressure) machine. R1's untitled services record dated January 2026, included: CPAP: Requires assistance putting CPAP on at HS (hour of sleep) and taking off in AM. R1's record lacked a treatment management plan to include the following required content:	01940		

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01940	Continued From page 23 - procedures for notifying a registered nurse when a problem arose with treatments or therapy services On January 28, 2026, at 10:24 a.m., CNS-B reviewed R1's record and stated it did not include specific direction for staff when to contact the nurse when issues arise related to R1's CPAP machine. The licensee's 7.05 Treatment & Therapy Management Plan policy dated July 2021, indicated: 1. Suite Living will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: d. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02320 SS=G	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	02320		

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02320	Continued From page 24 by: Based on observation, interview, and record review, the licensee failed to ensure healthcare and assisted living services were provided by people who were properly trained and competent to perform their duties including following the service plan for preventing skin breakdown and notifying a registered nurse (RN) of a change in condition related to skin breakdown for one of one dependent resident (R1). This resulted in an immediate correction order issued January 28, 2026, at approximately 1:30 p.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included spinal stenosis, congestive heart failure, atrial fibrillation, and type II diabetes. R1's Service Agreement signed February 11, 2025, indicated R1 required assistance with dressing, grooming, toileting, bathing, ambulation, transfers with two staff utilizing a Hoyer lift, catheter care, CPAP (continuous positive air pressure) machine, wound care, repositioning, medication administration, meals, and housekeeping. R1's Service Plan Report dated January 9, 2026,	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39149	A. BUILDING: _____ B. WING _____	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SENIOR CARE OF PRIOR LAKE	5600 CREDIT RIVER ROAD SE WHITE BEAR LAKE, MN 55110

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02320	Continued From page 25 indicated: Staff will notify RN immediately if fragile skin or breakdown is present. Observe for and report to the nurse any complaints of pain and/or requests for pain medications. Care staff will report any new complaint of pain. R1's untitled services record dated January 2026, indicated: - Resident needs to be transferred out of his w/c (wheelchair) after meals and put into bed or recliner to prevent pressure sores. - Repositioning Q2h (every two hours) R1's admission skin observation assessment dated February 11, 2025, indicated R1 had an unstageable right heel pressure ulcer measuring 8 cm (centimeters) in length, and 5 cm in width. The assessment further indicated R1 had redness to his coccyx. R1's recent assessment dated January 6, 2026, indicated staff apply Triad paste to buttocks daily with brief changes. R1's provider orders dated November 5, 2025, included: Triad hydrophilic wound dress external paste. Apply to buttocks wounds topically two times a day for wound care. Apply a thin layer. On January 26, 2026, at 4:13 p.m., the surveyor observed R1 seated in his recliner lift chair in his room with a Hoyer lift sheet underneath him. The lift chair was in what appeared to be the highest position. The surveyor greeted R1 and made a comment about the chair being up so high and feared he may fall out of it. R1 lowered the chair and stated his "my butt is killing me" and it felt better when he was in this position. The surveyor asked R1 if he had any sores on his bottom and he stated, "yes".	02320		

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02320	Continued From page 26 On January 27, 2026, at 8:12 a.m., the surveyor observed unlicensed personnel (ULP)-D administering medications to R1 in his room; R1 was lying on his back in bed watching television. Following the observation, the surveyor asked ULP-D if R1 had any sores on his bottom that they were treating. ULP-D stated R1 had some redness on his bottom and they apply a paste to it when they change him before getting him up for the day. ULP-D stated the paste is kind of "caked" on and difficult to remove when cleansing the area prior to reapplying. ULP-D further stated feeling bad when she cleanses the area as R1 will flinch like it hurts. ULP-D stated she hadn't observed the area for a few days and was unsure if the nurses were aware of it. The surveyor asked what time R1 gets up out of bed and ready for the day; she stated usually around 10:00 a.m., at which time they will transfer him to his recliner. On January 27, 2026, at 10:05 a.m., the surveyor observed ULP-D and ULP-E providing morning (AM) cares for R1. Prior to the ULPs performing the cares, the surveyor asked R1 if staff were repositioning him in his bed or in his chair and he stated "no." The surveyor further asked R1 if he would be agreeable to being repositioned from side to side to get the pressure off his bottom and he stated "yes." The surveyor then asked ULP-E if staff reposition R1 when in bed, and she stated they don't reposition him in bed, "He always lies on his back." ULP-E further stated after breakfast and AM cares they transfer him into his recliner and he's still there when they leave for the day (2:00 p.m.) ULP-D and ULP-E proceeded to perform care for R1 including emptying his catheter bag and applying a new bag. The ULPs then removed R1's brief, ULP-E provided peri-care for R1, then ULPs rolled R1	02320		

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	39149	A. BUILDING: _____ B. WING _____	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SENIOR CARE OF PRIOR LAKE	5600 CREDIT RIVER ROAD SE WHITE BEAR LAKE, MN 55110

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02320	Continued From page 27 onto his right side to cleanse his bottom before applying the Triad wound paste. R1's bottom was observed to be extremely reddened surrounding right and left gluteal clefts and buttocks. An open area was observed near the left gluteal crease that was approximately 2.5 cm in width. The surveyor asked ULP-D if the open area was present the last time she worked with R1 and she stated it wasn't. ULP-D further stated they looked much worse - more red and sore. ULP-D continued to assist holding R1 on his side while ULP-E cleansed R1's affected area on the buttocks and did not make any attempt to contact nursing to observe the area. At this time, the surveyor indicated to the ULPs that a nurse needed to observe the area, and exited the room to find a nurse. The surveyor informed regional director of nursing (RDON)-C of R1's open wound. The surveyor and RDON-C then returned to R1's room and RDON-C took over completion of the wound treatment including assessing and measuring the wound. RDON-C stated the redness to R1's bottom is not a new finding and that they have documentation on it. Per RDON-C's measurements at this time, R1's left gluteal had blanchable redness measuring 9.5 cm x 9 cm; open wound in center measuring 2.5 cm x 2 cm. R1's right gluteal was blanchable and measured 10.5 cm x 6 cm, wound in center measuring 4 cm x 0.5 cm; is stage 1 - red/purple in color and shaped like a straight line. RDON-C asked R1 if he was having any pain on his bottom. R1 stated he was and rated the pain 4-5 out of 10. RDON-C then directed ULP-D to administer PRN (as needed) Tylenol if available. Once RDON-C had completed the treatment and assisted staff with applying a clean brief for R1, ULPs then finished AM cares for R1 and transferred him into his recliner with the Hoyer lift.	02320		

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02320	Continued From page 28 On January 27, 2026, at 1:03 p.m., ULP-D and ULP-E stated they don't reposition R1 as it was not included in his care plan. The ULPs stated they get him out of bed at 10:00 a.m. and transfer him to his recliner. He can then position his recliner on his own, but they do not assist R1 with repositioning. ULP-D further stated the evening shift puts R1 back into his bed; probably after supper. On January 27, 2026, at 1:18 p.m., clinical nurse supervisor (CNS)-B stated R1 was to be repositioned and off-loaded every two hours. CNS-B stated this would be completed by using pillows to help him reposition from side to side. CNS-B further stated it is in his care plan to reposition and was unaware ULP-D and ULP-E were not completing this. CNS-B was also unaware the redness on R1's bottom had worsened as this wasn't an area she was monitoring weekly. On January 27, 2026, at 1:46 p.m., R1 stated once he gets up for the day, he stays in his recliner until he goes to bed for the night; usually until about 5:30 or 6:30 p.m. R1 stated neither the day or the evening shift try to reposition him in his chair, but he doesn't ask them to. R1 further stated if they wanted to do that (repositioning), it would be ok with him. R1 further stated they don't reposition him in bed either, "It doesn't hurt when I'm in bed". R1 changes his position in his recliner from sitting up to lying back. The surveyor asked if that helped relieve the pressure, and R1 stated there is a spot farther back that is sore, and if he (R1) changes position, it "helps the pain" and it "feels a lot better." On January 28, 2026, at 1:19 p.m., RDON-C stated staff are trained to notify the nurse of any	02320		

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02320	Continued From page 29 change of condition for the resident including a change in skin condition. CNS-B and RDON-C stated they would have expected to be notified of R1's increase in skin breakdown and pain. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On January 29, 2026, the licensee implemented corrective actions to address this issue. The scope and severity remains at G.	02320		

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

Food & Beverage Inspection Report

Establishment Info

Suite Living Senior Care of Pr
5600 Credit River Rd SE
Prior Lake, MN 55372
Scott County
Parcel:

Phone: 6517702273

License Info

License: 0042051

Risk:
License: -1
Expires on: 12/31/2023
CFPM: Jacquie Ann Enger
CFPM #: CFPM-22938; Exp: 10/26/2028

Inspection Info

Report Number: F1047261031
Inspection Type: Full - Single
Date: 1/27/2026 Time: 11:30 am
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

Inspection conducted with B. Perttula and reviewed with MDH Nurse Evaluator W. Buckholz.

The establishment has a commercial kitchen.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, and food handling procedures.

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 F1047261031 from 1/27/2026

Brie Perttula
Operator

Holly Sievers,
Public Health Sanitarian 3
651-201-5946
holly.sievers@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

Suite Living Senior Care of Pr
Prior Lake
County/Group: Scott County

Inspection Info

Report Number: F1047261031
Inspection Type: Full
Date: 1/27/2026
Time: 11:30 am

Food Temperature: Product/Item/Unit: Sausage**; Temperature Process:** Hot-Holding
Location: Steam Table at 173 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Lunch meats**; Temperature Process:** Cold-Holding
Location: #1 Hoshizaki Refrigerator at 38 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Milk**; Temperature Process:** Cold-Holding
Location: #2 Hoshizaki Refrigerator at 37 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

Establishment Info

Suite Living Senior Care of Pr
Prior Lake
County/Group: Scott County

Inspection Info

Report Number: F1047261031
Inspection Type: Full
Date: 1/27/2026
Time: 11:30 am

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 163 Degrees F.
Comment:
Violation Issued?: No