Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL339547703M
Compliance #: HL339547823C

Date Concluded: April 8, 2026

Name, Address, and County of Licensee Investigated:
Suite Living Senior Care of Roseville
197 County Road B2 West 10
Roseville, MN 55113
Ramsey County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Holly German, RN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The facility neglected the resident when they failed to follow the resident's diet order and was served food items that were not compliant to her diet order. The resident choked on the food and required hospitalization for a week.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility served the resident food that did not meet the guidelines for the resident's ordered diet of mechanical soft, minced, no bread, and no salad. The resident was served a BLT (bacon, lettuce, tomato) sandwich with toasted bread. Large pieces of bread and lettuce were removed from the resident's throat during the choking incident. The resident was hospitalized and required intubation.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The

investigation included review of the resident records, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report, related facility policy and procedures. Also, the investigator observed meal service and feeding assistance provided to the resident while on site.

The resident resided in an assisted living facility. The residents' diagnoses included parkinsonism, cognitive impairment, and difficulty swallowing. The resident's service plan included assistance with eating, toileting, mobility, transfers, and medication administration. The resident's assessment incorrectly indicated the resident was independent with communication, eating, and drinking.

The resident's provider orders indicated the resident's diet order, dated approximately four months prior to the choking incident, was mechanical soft texture, minced, no bread or salad.

The resident's progress note the day of the choking incident, authored by the facility nurse, indicated the resident had a choking episode earlier in the day during lunch. The note indicated the resident had soup with chicken in it when staff noticed the resident had difficulty, so back blows were delivered to the resident. The note indicated the resident was able to spit out the food. The note indicated staff noted the resident to have been having difficulty with food and liquid recently, including difficulty with water, watermelon and mashed potatoes over the past few weeks. The note lacked any documentation of intervention or notification to the resident's medical provider for this concern.

A progress note later in the day, indicated staff contacted the nurse to report the resident choked at dinner. Staff contacted the paramedics and sent the resident to the hospital.

The law enforcement report indicated law enforcement responded to the choking incident. The resident had been transitioned from pureed food to a minced, softened food diet and was given food that was not chopped up finely enough that led to the resident choking. The resident was hospitalized for one week and required intubation during the hospital stay.

The next day, a progress note indicated the resident admitted to the intensive care unit. Upon her arrival the night before, the resident's airway was occluded (blocked) and hospital staff were unable to intubate. An emergency bronchoscopy was performed and a "bunch of food was removed." The resident was then intubated.

A week later, a progress note indicated the resident returned to the facility. New prescribed orders instructed a clear liquid diet and nectar thick liquids. Staff must be present when the resident is eating or drinking.

A facility internal investigation document indicated the resident choked during dinner and was taken to the hospital. The document indicated there were four witnesses present during the incident (unlicensed personnel (ULP)-1, ULP-2, ULP-3, and the facility cook).

The facility document indicated during an internal investigation interview, the cook stated the meal served was a BLT, blueberries, raspberries, and potato rounds. The cook stated the resident's meal was cut up and minced to the size of a pea. The cook stated she cut up the resident's food extra small because she knew the resident did not wear her dentures, and the resident swallowed her food whole. The cook stated you can make bacon soft, and the toast was not hard. ULP-2 stated the resident's food was cut up, not finely cut, and was the size of a quarter. ULP-2 stated the resident did not eat the fruit and the BLT was toasted. ULP-2 stated the resident's diet order was finely cut, chopped up, and if the resident was to get finely chopped, then the resident's diet order was not followed. ULP-3 stated the resident's food was cut up to the size of a quarter when she choked on it. ULP-1 stated the resident's sandwich was cut up in small pieces, and she pulled pieces of bread out of the resident's mouth when the resident began choking. ULP-1 stated when emergency services staff arrived, they pulled a big piece of lettuce out of the resident's throat, and once the lettuce was removed, the resident started to have color return to her face. ULP-1 stated she did not believe the resident's diet order was followed because the bacon on the sandwich was crispy and the piece of lettuce was long.

A facility provided document that included pictures and descriptions of altered diet types indicated chopped foods required to be a half to three quarters of an inch in size, and minced foods required to be one sixteenth to one eighth inch in size. The document indicated to eat lettuce on a mechanically soft diet, it should be shredded or minced and mixed with moist ingredients to keep it from getting dry.

During an interview, the nurse stated her typical work duties included communication to the residents' providers and families and was responsible for all resident assessments. The nurse stated if a resident had difficulty swallowing, the information was sent to their provider to get an order on how to proceed such as a diet change or to get a swallow study done. The nurse stated staff know the residents' diet orders because they were listed on their care plans on the computer, in the paper care plans in their charts, and in the care plan book at the nurse's station. The nurse stated there was also a whiteboard on the kitchen door with a chart that stated where the resident sat for meals and any special precautions they may need. The nurse stated if there were changes to a resident's diet, it was written in the communication book, and verbal updates were given during shift changes. The nurse stated staff received training upon hire on resident diet types. The RN stated the cook prepares regular meals first, then any special diets next. The nurse stated the cook was responsible for ensuring residents are given the correct meal at mealtime, as she always communicated resident diets to the cook verbally and by written form. The nurse stated difficulty swallowing is a change in condition and should be reported to the resident's provider. The nurse stated the resident did not like to wear her teeth and did not believe the resident was on a special diet prior to the choking incident.

During an interview, ULP-1 stated at meals times, the cook set the plates out and told them which resident it was for. ULP-1 stated the residents' diets were listed on the computer, and

staff learned every residents' diet over time. ULP-1 stated if a caregiver did not know what diet a resident had, the cook handed it to them, and they assumed the cook knew. ULP-1 stated the resident received a cut up BLT and was feeding herself during the meal when she had a choking incident. ULP-1 stated there were days the resident could feed herself, and days she needed assistance. ULP-1 stated the resident began to cough, and when staff realized she was not clearing the cough, they removed her from the dining room and attempted the Heimlich maneuver. ULP-1 stated another staff member called 911, and the resident was placed on the floor. ULP-1 stated law enforcement arrived, and they pulled a long piece of lettuce and pieces of sandwich out of the resident's throat before taking the resident to the hospital. ULP-1 stated the resident's diet was constantly changed flipping back and forth from chopped, mechanical soft, and puree prior to the choking incident. ULP-1 stated the BLT was chopped into pieces the size of a quarter.

During an interview, the cook stated she had quite a bit of training on resident diet types from previous places of employment but did not receive any training regarding diet types at the facility until after the resident's choking incident. The cook stated the nurse would let her know what a resident's diet order was and of any changes. The cook stated the nurse was responsible for ensuring residents' diet orders were correct, and she was responsible for serving the right food. The cook stated the resident's diet at the time of the choking incident was mechanical soft, and that meant she could not have certain fruits, bacon or lettuce. The cook stated sausage was substituted for bacon. The cook stated the resident would have received toasted bread, sausage, cooked vegetable, and a fruit that would have been diced all the way down to minced. The cook stated the sandwich would have been minced, like liquid texture, and it was provided to the resident that way. The cook denied the resident would have received a BLT with toasted bread or lettuce on it, because the resident could not have those items with her diet order. Staff may have brought the resident the wrong tray.

During an interview, ULP-2 stated she received training on different resident diet types at the facility. ULP-2 stated mechanical soft foods were finely chopped, like minced. ULP-2 stated the caregivers gave the meals to each resident when the cook handed the meal tray to them and told them what resident it was for. ULP-2 stated the caregivers should ensure the resident received the right diet. ULP-2 stated during the meal of the choking incident, the resident had a mechanical chopped diet, and it had previously been pureed. ULP-2 stated staff had a meeting prior to the choking incident where the nurse stated she was trying to get it changed back to pureed. ULP-2 stated the resident received a toasted sandwich, and it was chopped the size of a quarter. ULP-2 stated she believed the toasted texture of the bread and the size of the sandwich pieces are what caused the resident to choke since the resident had been on pureed diet prior.

During an interview, a manager stated all staff handed out resident meal trays, and they should make sure residents received the correct type of diet for the meal. The manager stated residents' diets were posted everywhere, including in their chart and on the kitchen door. The manager stated there was a company who can come to the facility for swallowing and speech

therapy services if needed. The manager stated if a resident was noted to have swallowing issues, the nurse is notified immediately and must report the concern to the resident's provider. The manager stated she did not recall what the resident's diet order was at the time of the incident, but recalled there was a lot of back and forth around that time for puree, chopped, and minced diet orders. The manager stated the cook did not receive training upon hire at the facility regarding resident diets because the cook already had certificates that meant she had already received training for it. The manager said the nurse and the cook were responsible for ensuring the residents received the correct diet.

The resident was nonverbal and could not complete an interview.

The resident's family did not return the requests for interview.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No, non-verbal.
Family/Responsible Party interviewed: No, did not return request for interview.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The staff responded timely to the choking incident, attempted the Heimlich maneuver, and ensured the resident received medical treatment as necessary.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Ramsey County Attorney
Roseville City Attorney
Roseville Police Department
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33954	A. BUILDING: _____ B. WING _____	C 02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING OF ROSEVILLE	197 COUNTY ROAD B2 WEST ROSEVILLE, MN 55113

(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 CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: HL339547823C/HL339547703M On February 24, 2026, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 20 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for HL339547823C/HL339547703M, tag identification 2310, 2360.	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.	
02310 SS=J	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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02310	Continued From page 1 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to provide a meal within the dietary parameters as ordered by the medical provider, as required for 1 of 1 residents (R1) reviewed. R1 experienced a choking incident and was hospitalized. This practice resulted in a level four violation (a violation that harmed a resident ' s health or safety, not including serious injury or death, or a violation that was likely to lead to serious injury or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's diagnosis includes Parkinson's, cognitive impairment, and difficulty swallowing. R1's service plan dated December 4, 2025, indicated R1 received assistance with transfers, mobility, eating, bathing, and medication administration. R1's medical provider order for diet dated June 9, 2025, identified R1's diet order as mechanical soft texture, regular consistency, minced, no bread, and no salad. R1's progress note dated October 21, 2025, at 3:17 p.m., authored by registered nurse (RN)-A,	02310		

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02310	Continued From page 2 indicated R1 experienced a choking episode during the lunch time meal when R1 ate soup with chicken in it. The note indicated R1 had difficulty with foods and liquids recently over a few weeks. R1's progress note dated October 21, 2025, at 6:06 p.m., by RN-A, indicated staff reported R1 was choking during dinner. Staff contacted paramedics and sent R1 to the hospital. A law enforcement report dated November 4, 2025, at 9:46 a.m., indicated R1 was given food on October 21, 2025, that was not chopped up finely and led to R1 choking. Following the choking episode, R1 was hospitalized for one week and required intubation during the hospital stay. R1's progress note dated October 22, 2025, indicated R1 was admitted to the intensive care unit. Upon her arrival the night before, R1's airway was occluded (blocked) and staff were unable to intubate. An emergency bronchoscopy was performed and a "bunch of food was removed." R1 was then intubated. R1's progress note datd October 27, 2025, indicated R1 returned to the facility. New prescribed diet orders instructed a clear liquid diet and nectar thick liquids. Staff must be present when she is eating or drinking. A licensee provided document, untitled and undated, indicated chopped foods required to be a half to three quarters of an inch in size, and minced foods required to be one sixteenth to one eighth inch in size. The document indicated that to eat lettuce on a mechanically soft diet, it should be shredded or minced and mixed with moist	02310		

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02310	Continued From page 3 ingredients to keep it from getting dry. During an interview on February 27, 2026, at 8:02 a.m., RN-A stated R1 did not like to wear her teeth and did not believe R1 was on a special diet at the time of the choking incident. During an interview on February 27, 2026, at 9:04 a.m., unlicensed personnel (ULP)-B stated caregivers should know what the residents' diet are, but if they did not, they assumed the cook did when she gave them the meal tray. ULP-B stated R1's care plan stated R1's diet was cut up. ULP-B stated R1 choked on the BLT (bacon, lettuce, tomato) sandwich that was served to her in cut up pieces. ULP-B stated a police officer arrived and pulled a very long piece of lettuce out of R1's throat. ULP-B stated R1's diet orders had frequent changes around the time of the incident, and ULP-B felt R1 should have received a mechanical soft diet, not a chopped one. During an interview on March 2, 2026, dietary staff (DS)-C stated she did not receive training upon hire by the licensee regarding resident altered diets. DS-C stated she received resident dietary orders from RN-A and handed the prepared meal trays directly to the caregivers after telling the caregiver which resident it was for. DS-C stated she watched the caregivers deliver the meal trays to ensure they were delivered to the correct resident. DS-C stated R1 had a dietary order of mechanical soft at the time of R1's choking incident, therefore R1 would have received toasted bread, sausage, cooked vegetables, and fruit to meet mechanical soft guidelines of a BLT sandwich. DS-C stated the sandwich would have been minced to a liquid like consistency to meet the guidelines of R1's dietary order. DS-C stated R1 could not have toast or	02310		

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02310	Continued From page 4 lettuce per her dietary order. DS-C stated she was not aware that pieces of lettuce and bread had been removed from R1's mouth, and staff may have brought the wrong meal tray to R1. During an interview on March 3, 2026, at 10:00 a.m., ULP-D stated the caregivers should have checked R1 received the correct diet on her meal tray. ULP-D stated R1 had a recent hospital stay and returned with a diet order of mechanical chopped, even though R1's diet order was pureed prior to the hospital stay. ULP-D stated RN-A held a meeting where staff were notified RN-A was attempting to get R1's diet order changed back to puree. ULP-D stated R1 was served a toasted sandwich, chopped in the size of a quarter. ULP-D stated she believed the texture and size of the sandwich caused R1 to choke. The licensee-provided policy titled Dining Service, dated August 1, 2021, indicated staff will be aware of any special diets/food preparations that were ordered or required and for which resident. The licensee provided policy titled Special Diets, dated August 1, 2021, indicated special diets available included pureed, soft and bite sized, minced and moist, liquidized, and thickened liquids. The policy indicated special diets were coordinated between food service and nursing staff for accommodation and appropriateness. TIME PERIOD FOR CORRECTION: Two (2) days	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial	02360		

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02360	Continued From page 5 exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		