DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

December 6, 2021

Administrator
Suite Living Senior Care
7900 Austin Way
Inver Grove Heights, MN 55077

RE: Project Number(s) SL36603015-1

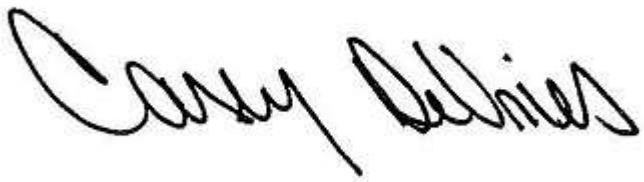
Dear Administrator:

On November 22, 2021, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the September 15, 2021, evaluation were corrected. The follow-up evaluation verified that the facility is back in compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,



Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

PMB

Electronically Delivered

October 19, 2021

Administrator
Suite Living Sr Of IGH
7900 Austin Way
Inver Grove Heights, MN 55077

RE: Project Number(s) SL36603015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on September 15, 2021, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

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

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and 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 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572. subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), immediate fine imposition is authorized for both surveys and investigations conducted. When a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the client(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's clients/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 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 the Department of Health within 15 calendar days.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917
Fax: 651-215-6894

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36603	A. BUILDING: _____ B. WING _____	09/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SR OF IGH	7900 AUSTIN WAY INVER GROVE HEIGHTS, MN 55077

(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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.10 to 144G.93, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL#36603015 On, September 14 through September 15, 2021, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 31 residents receiving services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 450 SS=C	144G.41 Subdivision 1 Minimum requirements	0 450		

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0 450	Continued From page 1 All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the current bill of rights for assisted living (BOR) to three of three residents (R1, R2, R3) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). Findings include: R1, R2, and R3's records included an "Acknowledgements" form that indicated residents received BOR upon admission to facility. R1 admitted date was December 1, 2020. R2 admitted date was May 17, 2021.	0 450		

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0 450	Continued From page 2 R3 admitted date was October 21, 2020. On September 15, 2021, at approximately 1:00 p.m., director of operations (DOO)-C stated residents all received a copy of the BOR dated November 2019 as included in policy. DOO-C stated the licensee was not aware of the current BOR to be provided to residents was dated May 16, 2021. Licensee's "2.05 Bill of Rights" policy dated July 19, 2021, included a BOR dated November 2019. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 450		
01370 SS=F	144G.61 Subd. 2 Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting;	01370		

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01370	Continued From page 3 (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure two of two unlicensed personnel (ULP-B and ULP-F) received the required training/competency testing with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	01370		

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01370	Continued From page 4 The findings include: R5's untitled document dated July 21, 2021, indicated for mobility, "Escort needed to/from activities and or dining room," and "Mobile with assistive device: wheelchair." On September 15, 2021, at approximately 7:45 a.m., observed ULP-B escort R5 from bedroom to dining area in a Broda (wheelchair with tilt-in-space options and footrests for long-term and complex settings) without footrests. R5 held their feet off floor as ULP-B pushed the wheelchair, which created a risk for injury if R5 were to let feet fall to floor. On September 15, 2021, at approximately 10:30 a.m., director of operations (DOO)-C stated wheelchair safety training occurs during orientation but no specific documentation on topics covered would be included in the training transcripts for employees. On September 15, 2021, at approximately 11:20 a.m., ULP-B and ULP-F stated training on the topic of wheelchair safety was provided during orientation but they could not remember topics covered. On September 15, 2021, at approximately 1:00 p.m., DOO-C and Regional Director of Nursing (RDON)-D stated all employees should use footrests when escorting residents with wheelchairs. No policy provided by licensee. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one	01370		

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01370	Continued From page 5 (21) days.	01370		
01620 SS=F	144G.70 Subd. 2 Initial reviews, assessments, and monitoring (c) Resident reassessment 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. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) 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 observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment to include all areas required on the uniform assessment tool for three of three residents (R1, R2, R3) with records reviewed.	01620		

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01620	Continued From page 6 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: R1's 90-day reassessment titled Client Monitoring Visit Notes dated September 13, 2021, lacked areas required on the uniform assessment tool including a full physical and cognitive assessment. R1's service plan dated December 1, 2020, indicated R1 received services, which included but were not limited to, medication administration, oxygen therapy, housekeeping, and assistance with bathing and grooming. R1's record included a Client Monitoring Visit Note dated September 13, 2021. The document indicated that R1 would continue with current services, however, did not include all of the elements on the uniform assessment tool as required. On September 15, 2021, at approximately 8:00 a.m., unlicensed personnel (ULP)-G was observed administering medications to R1. R2's 90-day titled Client Monitoring Visit Notes dated August 25, 2021, lacked areas required on the uniform assessment tool including a full physical and cognitive assessment.	01620		

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01620	Continued From page 7 R2's service plan dated May 17, 2021, indicated R2 received services, which included but were not limited to, medication administration, medication set-up, housekeeping, and activities of daily living. R3's 90-day titled Client Monitoring Visit Notes dated August 6, 2021, lacked areas required on the uniform assessment tool including a full physical and cognitive assessment. R3's service plan dated October 21, 2020, indicated R3 received services, which included, but were not limited to, medication administration, medication set-up, housekeeping, and activities of daily living. On September 15, 2021, at approximately 1:00 p.m., registered nurse (RN)-A, director of operations (DOO)-C, regional director of nursing (RDON)-D, and Regional Director of Operations-E stated assessments were completed but lacked content from uniform assessment tool. RDON-D stated the licensee was not aware contents of the uniform assessment tool were required to be completed with assessments or reassessments. Licensee's "Assessments, Reviews & Monitoring" policy, dated July 20, 2021, included assessment schedule with appropriate timing, but lacked identification for completing uniform assessment tool content with assessment or reassessment. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		

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01650	Continued From page 8	01650		
01650 SS=A	144G.70 Subd. 4 Service plan, implementation, and revisions t (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; (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 the service plan included the required content for one of three residents (R1) with records reviewed. This practice resulted in a level one violation (a	01650		

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01650	Continued From page 9 violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) 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). Findings include: On September 15, 2021, at approximately 8:15 a.m., unlicensed personnel (ULP)-G was observed providing treatments to R1 to include blood glucose monitoring and application of TED (compression socks used to prevent blood clots) stockings. R1's Service Agreement dated December 1, 2020, lacked identification of blood glucose monitoring and application of TED stocking services to be provided. On September 15, 2021, at 1:00 p.m., director of operations (DOO)-C stated resident service plans should include all services provided by the licensee, including those outlined in treatment and medication management plans. The licensee's Service Plan policy dated July 20, 2021, included all required content for Minnesota Statute 144G.70 subd. 4. No further information was provided. Time period for correction: Twenty-One (21) days.	01650		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current	01730		

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01730	Continued From page 10 individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop an individualized medication management record	01730		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01730	Continued From page 11 with the required content for three of three residents (R1, R2, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On September 15, 2021, at approximately 8:00 a.m., unlicensed personnel (ULP)-G was observed administering medications to R1. R1's Individualized Medication Management Plan dated December 1, 2020, lacked written procedures for staff to notify a registered nurse (RN) or appropriate licensed health professional when a problem arises. On September 15, 2021, at 11:30 a.m., ULP-G stated there are no specific instructions for when staff should report changes to a nurse. ULP-G further stated they (staff) can write in Teams (an electronic report) to communicate to others what happened during their shift. R2's service plan dated May 17, 2021, indicated medication administration was assigned to "HHA (Home Health Aide/ULP), RN, LPN." R2's Individualized Medication Management Plan dated May 17, 2021, lacked procedures for ULPs to notify a nurse if problems arise.	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36603	A. BUILDING: _____ B. WING _____	09/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SR OF IGH	7900 AUSTIN WAY INVER GROVE HEIGHTS, MN 55077

(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
01730	Continued From page 12 R3's service plan dated October 21, 2020, indicated medication administration was assigned to "HHA (Home Health Aide/ULP), RN, LPN." R3's Individualized Medication Management Plan dated October 21, 2020, lacked procedures for ULPs to notify a nurse if problems arise. On September 15, 2021, at approximately 1:00 p.m., (RN)-A and director of operations (DOO)-C acknowledged staff do not have specific instructions for notifying the RN or licensed health professional when problems arise and are not provided with documentation or training on what specific changes to report to the RN. Licensee's "Medication Management Individualized Plan" policy dated July 2021 included all required content related to Minnesota Statute 144G.71 subd. 5. No further information was provided. Time period for correction: Seven (7) days	01730		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet	01760		

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	36603	A. BUILDING: _____ B. WING _____	09/15/2021

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01760	Continued From page 13 the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were labeled correctly for one of four residents (R7) with records reviewed. 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). Findings include: On September 15, 2021, at approximately 11:30 a.m., the locked medication cart was reviewed, and the following was observed: R7's Lantus Solostar 100u (units)/ml (milliliter) and Lispro Injection Kwikpen 100u/ml (both insulin pens) labels both lacked the dates the medications were opened and the expiration date. Manufacturer's instructions for Lantus indicated the pen should be discarded after 28 days. Manufacturer's instructions for Lispro indicated the pen should be discarded after 28 days. On September 15, 2021, at 1:00 p.m., registered nurse (RN)-A and director of operations (DOO)-C acknowledged all insulin pens should be dated when opened per their policy and expectation. The licensee's Insulin Pen policy dated August 1, 2021, included all required content related to Minnesota Statute 144G.71 subd. 8. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7)	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36603	A. BUILDING: _____ B. WING _____	09/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SR OF IGH	7900 AUSTIN WAY INVER GROVE HEIGHTS, MN 55077

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01760	Continued From page 14 days.	01760		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy 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	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36603	A. BUILDING: _____ B. WING _____	09/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SR OF IGH	7900 AUSTIN WAY INVER GROVE HEIGHTS, MN 55077

(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
01940	Continued From page 15 review, the licensee failed to develop a treatment management plan to include all required content for one of three residents (R1) with records reviewed. 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). Findings include: R1's service plan, dated December 1, 2020, lacked any mention the resident received the treatment services of blood sugar monitoring, skin fold care, and assistance with TED hose (compression stockings used to prevent blood clots). Additionally, R1's service plan regarding treatments lacked procedures for notifying a nurse or appropriate licensed health professional if a problem would arise with the treatments or therapy services. On September 15, 2021, at approximately 8:15 a.m., unlicensed personnel (ULP)- G was observed administering the following treatments to R1: blood glucose monitoring and application of TED hose. On September 15, 2021, at 1:00 p.m., registered nurse (RN)-A and director of operations (DOO)-C acknowledged staff do not have specific instructions when to contact the RN or licensed health professional with issues that arise with treatments.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36603	A. BUILDING: _____ B. WING _____	09/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01940	Continued From page 16 The licensee's Treatment & Therapy Management Plan policy, dated July 2021, had all required content related to Minnesota Statute 144G.72 subd. 3. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01940		
02040 SS=D	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility lacked proper documentation a hazard vulnerability or safety risk assessment had been performed on and around the property. The hazards indicated must be assessed and mitigated to protect the residents from harm. This had the potential to directly affect all dementia care residents. This practice resulted in a level two violation (a	02040		

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	36603	A. BUILDING: _____ B. WING _____	09/15/2021

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02040	Continued From page 17 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 14, 2021, at approximately 11:25 a.m., review of facility records provided no evidence of complete hazard vulnerability assessment. This is required per statute and could result in harm to residents, staff, and visitors if not completed. On September 14, 2021, at approximately 11:45 a.m., Regional Director of Operations-E, acknowledged the facility had not fully developed the required hazard vulnerability assessment. Global issues such as fire, gas leak, epidemic, and shooter had been identified. Mitigation procedures had not been developed. Local hazards that are site, building, and population specific had not been developed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

Minnesota Department of Health
Food, Pools & Lodging Services
P. O. Box 64975
Saint Paul, Mn. 55164-0975
651-201-4500

Type: Full
Date: *09/14/21*
Time: 10:35:21
Report: 7958211198

Food and Beverage Establishment Inspection Report

Location:
Suite Living Seniorcare of IGH
7900 Austin Way
Inver Grove Heights, Mn
Dakota County, 19

Establishment Info:
ID #: N091421
Risk:
Announced Inspection: No

License Categories:
Cat3

Expires on: / /

Operator:

Phone #:
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Wash temperature gauge: = at 164 Degrees Fahrenheit
Location: Jackson high temp dish machine
Violation Issued: No

Final rinse temperature ga: = at 196 Degrees Fahrenheit
Location: Jackson high temp dish machine
Violation Issued: No

Utensils surface temperatu: = at 165.9 Degrees Fahrenheit
Location: Jackson high temp dish machine
Violation Issued: No

Ambient air temperature: = at 38 Degrees Fahrenheit
Location: Hoshizaki double door reach-in refrigerator
Violation Issued: No

Ambient air temperature: = at 36 Degrees Fahrenheit
Location: Hoshizaki douboe door reach-in refrigerator
Violation Issued: No

Ambient air temperature: = at 6 Degrees Fahrenheit
Location: Hoshizaki double door freezer
Violation Issued: No

Ambient air temperature: = at 2 Degrees Fahrenheit
Location: Hoshizaki double door freezer
Violation Issued: No

Quaternary ammonium: = 150+ pp at Degrees Fahrenheit
Location: Wiping cloth bucket
Violation Issued: No

Quaternary ammonium: = 300+ pp at Degrees Fahrenheit
Location: Dispenser at 3 compartment sink
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/Hd boiled eggs
Temperature: 38 Degrees Fahrenheit - Location: Hoshizaki double door reach-in
Violation Issued: No

Process/Item: Cold Hold/Roast beef
Temperature: 39 Degrees Fahrenheit - Location: Hoshizaki double door reach-in
Violation Issued: No

Process/Item: Cold Hold/Cheese slices
Temperature: 38 Degrees Fahrenheit - Location: Hoshizaki double door reach-in
Violation Issued: No

Process/Item: Cold Hold/Liq. egg
Temperature: 38 Degrees Fahrenheit - Location: Hoshizaki double door reach-in
Violation Issued: No

Process/Item: Cold Hold/Goulash
Temperature: 37 Degrees Fahrenheit - Location: Hoshizaki double door reach-in
Violation Issued: No

Process/Item: Cold Hold/Milk
Temperature: 38 Degrees Fahrenheit - Location: Hoshizaki double door reach-in
Violation Issued: No

Process/Item: Cold Hold/Sour cream
Temperature: 37 Degrees Fahrenheit - Location: Hoshizaki double door reach-in
Violation Issued: No

Process/Item: Cold Hold/Diced apples
Temperature: 36 Degrees Fahrenheit - Location: Hoshizaki double door reach-in (bulk storage)
Violation Issued: No

Process/Item: Cold Hold/Romaine lettuce
Temperature: 38 Degrees Fahrenheit - Location: Hoshizaki double door reach-in (bulk storage)
Violation Issued: No

Process/Item: Cook/Chicken breasts
Temperature: Degrees Fahrenheit - Location: Southbend oven
Violation Issued: No

Food and Beverage Establishment Inspection Report

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	0

REVIEWED THE SYMPTOMS OF FOODBORNE ILLNESSES AND THE REQUIREMENT TO MAINTAIN A DOCUMENTED RECORD OF ALL INSTANCES OF EMPLOYEES BEING ILL WITH EITHER VOMITING OR DIARRHEA AS REQUIRED BY THE MINNESOTA FOOD CODE & EXCLUDE ILL WORKERS FROM WORKING WITH FOOD & BEVERAGES UNTIL 24 HOURS AFTER SYMPTOMS HAVE ENDED.

MAINTAINING AN ACCURATE RECORD OF ALL INSTANCES OF EMPLOYEES BEING ILL WITH VOMITING AND/OR DIARRHEA MAY PROVIDE A FIRST INDICATION OF INCREASED RISK OF A FOODBORNE ILLNESS TO PERSONS AS A RESULT OF EATING AT A FOOD SERVICE ESTABLISHMENT.

**IF ANY CUSTOMER COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE CUSTOMER. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

THE TEMPERATURE OF THE SANITIZING RINSE (UTENSIL SURFACE TEMPERATURE) INSIDE THE DISH MACHINE WAS MEASURED AT 165.9 DEGREES F., WHICH IS ABOVE THE MINIMUM UTENSIL SURFACE TEMPERATURE OF 160 DEGREES F THAT IS REQUIRED BY THE MINNESOTA FOOD CODE. AT THIS TIME, THE DISH MACHINE IS PROPERLY SANITIZING.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 7958211198 of 09/14/21.

Certified Food Protection Manager: Cassandra Aszmann

Certification Number: FM71589 Expires: 02/15/23

Inspection report reviewed with person in charge and emailed.

Signed: _____
Cassandra Aszmann
Chef

Signed: _____
George Wahl, #7958
REHS
MDH - Freeman Building
651-201-4188
george.wahl@state.mn.us