Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL390818702M
Compliance #: HL390816303C

Date Concluded: May 9, 2025

Name, Address, and County of Licensee Investigated:
Round Lake Senior Living
1740 Parkshore Drive
Arden Hills, MN 55112
Ramsey County

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

Evaluator's Name: Lori Pokela
Special Investigator

Finding: Inconclusive

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 care was not provided in accordance with the service plan or plan of care.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. There was not a preponderance of evidence to support that staff did not provide necessary cares or services. When incidents occurred, staff assessed, monitored, and implemented interventions. When the resident's motion-alert electronic, alarm system was reported to not be working properly, maintenance was completed.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted a hospice case worker. The investigation included review of the resident record(s), death record, hospital records, facility internal investigation documentation, facility incident reports, personnel files, staff schedules,

and related facility policy and procedures. Also, the investigator interviewed other residents, observed the facility environment, medication administration, treatment administration, and care provided by staff.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, left hip fracture, left humoral (upper arm bone) fracture, and history of colon and lung cancer. The resident's service plan included assistance with bathing once a week, dressing, grooming, two staff assist with the mechanical lift, meal assistance, turning and repositioning twice per day, medication management and specialized treatments. The resident's assessment indicated the resident had impaired memory, cognition, confusion and behaviors that included verbal aggression.

Video footage provided identified the resident crawling around on the floor of her room. One video showed the resident crawling on the floor of her room, before lifting herself up into bed, while the other video only showed the resident crawling on the floor. The videos did not provide details of how the resident got on the floor. There was a lack of documentation provided to determine if the two video incidents were reported to staff.

In a third incident, staff found the resident on the floor. Staff assessed the resident, reported the incident, and transported the resident to the hospital where she was diagnosed with a fractured right femur and right shoulder.

When the resident returned to the facility on hospice services.

During interview, facility administrative nursing staff stated the memory care unit the resident resided on did not use call/pendent lights to alert staff of resident assistance. The facility used a motion-alert electronic alarm system to detect sudden changes in motion and staff completed hourly checks on the memory care residents.

During an interview, unlicensed staff stated they responded to the resident's most recent fall after hearing the resident yell while completing safety checks.

During an interview, the resident's family member stated they reported the resident's motion-alert electronic alarm system was not working properly and staff tested the system by going in the resident's room and crawling on the floor to see if activated the signal.

During an interview, the resident's hospice nurse stated they observed no concerns regarding the resident's care and when hospice provided care the resident appeared comfortable.

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

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

“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. Deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:

- The facility completed an incident report and facility investigation of the most recent fall. The facility provided re-education to nursing staff on safe transfers, answering call lights and documentation.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc:

The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39081	A. BUILDING: _____ B. WING _____	C 03/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROUND LAKE SENIOR LIVING	1740 PARKSHORE DRIVE ARDEN HILLS, MN 55112

(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 On March 10, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL390816303C/#HL390818702M. No correction orders are issued.	0 000		