



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 26, 2025

Licensee
Round Lake Senior Living
1740 Parkshore Drive
Arden Hills, MN 55112

RE: Project Number(s) SL39081016

Dear Licensee:

On November 27, 2025, the Minnesota Department of Health completed a follow-up SL39081016 of your facility to determine correction of orders from the facility completed on October 16, 2025. This follow-up **SL39081016** verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Jess Schoenecker'.

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

KKM



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 12, 2025

Licensee
Round Lake Senior Living
1740 Parkshore Drive
Arden Hills, MN 55112

RE: Project Number(s) SL39081016

Dear Licensee:

Please note: refer to the revised state form for details of the revisions to tag 2310.

The Minnesota Department of Health (MDH) completed a survey on October 16, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement;

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 5: a fine of \$5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - \$500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

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

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: <https://forms.office.com/g/Bm5uQEpHVva>. 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,

A handwritten signature in black ink that reads "Renee L. Anderson". The signature is written in a cursive, flowing style.

Renee L. Anderson, Supervisor

State Evaluation Team

Email: Renee.L.Anderson@state.mn.us

Telephone: 651-201-5871 Fax: 1-866-890-9290

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39081	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/16/2025
NAME OF PROVIDER OR SUPPLIER ROUND LAKE SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 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 *****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: SL #39081016-0 On October 13, 2025, through October 16, 2025, 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 120 residents, 84 of whom were receiving services under the provider's Assisted Living Facility with Dementia Care license. *****REVISED***** On December 11, 2025, for consistency in application of the requirements, the 2310 order was edited to change the severity from level 3 to a level 2 and the time period for correction from an immediate order to 2 days.	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 License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the 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 pursuant to 144G.31 Subd. 1, 2 and 3.		
0 130 SS=C	144G.12, Subd. 1 Application for Licensure Each application for an assisted living facility	0 130			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 130	Continued From page 1 license, including provisional and renewal applications, must include information sufficient to show that the applicant meets the requirements of licensure, including: (1) the business name and legal entity name of the licensee, and the street address and mailing address of the facility; (2) the names, e-mail addresses, telephone numbers, and mailing addresses of all owners, controlling individuals, managerial officials, and the assisted living director; (3) the name and e-mail address of the managing agent and manager, if applicable; (4) the licensed resident capacity and the license category; (5) the license fee in the amount specified in section 144.122; (6) documentation of compliance with the background study requirements in section 144G.13 for the owner, controlling individuals, and managerial officials. Each application for a new license must include documentation for the applicant and for each individual with five percent or more direct or indirect ownership in the applicant; (7) evidence of workers' compensation coverage as required by sections 176.181 and 176.182; (8) documentation that the facility has liability coverage; (9) a copy of the executed lease agreement between the landlord and the licensee, if applicable; (10) a copy of the management agreement, if applicable; (11) a copy of the operations transfer agreement or similar agreement, if applicable; (12) an organizational chart that identifies all organizations and individuals with an ownership interest in the licensee of five percent or greater	0 130			

Minnesota Department of Health

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0 130	Continued From page 2 and that specifies their relationship with the licensee and with each other; (13) whether the applicant, owner, controlling individual, managerial official, or assisted living director of the facility has ever been convicted of: (i) a crime or found civilly liable for a federal or state felony level offense that was detrimental to the best interests of the facility and its resident within the last ten years preceding submission of the license application. Offenses include: felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; any felonies involving malpractice that resulted in a conviction of criminal neglect or misconduct; and any felonies that would result in a mandatory exclusion under section 1128(a) of the Social Security Act; (ii) any misdemeanor conviction, under federal or state law, related to: the delivery of an item or service under Medicaid or a state health care program, or the abuse or neglect of a patient in connection with the delivery of a health care item or service; (iii) any misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service; (iv) any felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in Code of Federal Regulations, title 42, section 1001.101 or	0 130			

Minnesota Department of Health

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0 130	Continued From page 3 1001.201; (v) any felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; (vi) any felony or gross misdemeanor that relates to the operation of a nursing home or assisted living facility or directly affects resident safety or care during that period; (vii) any revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority; (viii) any revocation or suspension of accreditation; or (ix) any suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or nonprocurement program; (14) whether, in the preceding three years, the applicant or any owner, controlling individual, managerial official, or assisted living director of the facility has a record of defaulting in the payment of money collected for others, including the discharge of debts through bankruptcy proceedings; (15) the signature of the owner of the licensee, or an authorized agent of the licensee; (16) identification of all states where the applicant or individual having a five percent or more ownership, currently or previously has been licensed as an owner or operator of a long-term care, community-based, or health care facility or agency where its license or federal certification has been denied, suspended, restricted, conditioned, refused, not renewed, or revoked	0 130			

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0 130	Continued From page 4 under a private or state-controlled receivership, or where these same actions are pending under the laws of any state or federal authority; (17) statistical information required by the commissioner; and (18) any other information required by the commissioner. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to meet the requirements of licensure for the assisted living (AL) license they possessed. The license indicated a total capacity of 116, however there was potential for 120 residents. This practice resulted in a level one violation (a violation that will cause only 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 the potential to affect a large portion or all the residents). The findings include: The licensee's Application for Assisted Living License, signed by the licensee's assisted living director (LALD)-A on November 21, 2024, indicated the total licensed resident capacity for the current licensed period was 116. On October 13, 2025, at 12:45 p.m., the surveyor observed the licensee's Assisted Living License certificate in a picture frame located on a stand behind the reception desk. The certificate was for the current licensing period of January 6, 2025, to January 5, 2026, and indicated a capacity of 116.	0 130			

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0 130	Continued From page 5 On October 13, 2025, at 2:46 p.m., LALD-A stated via email, there were 84 residents receiving assisted living services and 36 independent living residents (a total of 120 residents). -at 2:55 p.m., LALD-A stated they did not know the capacity count included non-assisted residents and they would have to check with leadership because it was "not my area." On October 14, 2025, at 1:29 p.m., LALD-A stated the licensee had sent a request to increase the license capacity. LALD-A further stated the total number of residents originally given to the surveyor (120) included two people renting an apartment who had not moved in yet, and another resident who had just moved out. On October 15, 2025, at 11:02 a.m., LALD-A provided the surveyor the licensee's Licensed Resident Capacity Increase Request form, signed by authorized agent (AA)-I, dated October 13, 2025 (during the survey period). The form indicated the licensee requested the resident capacity be increased from 116 to 132. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 130			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed	0 480			

Minnesota Department of Health

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0 480	Continued From page 6 capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb	0 480			

Minnesota Department of Health

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0 480	Continued From page 7 breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 14, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 510 SS=F	144G.41 Subd. 3 Infection control program	0 510			

Minnesota Department of Health

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0 510	Continued From page 8 (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b) The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control, which included ensuring direct care staff appropriately gloved and performed adequate hand hygiene (HH) and cleaned reusable point of care medical equipment, for 2 of 2 staff observed (unlicensed personnel (ULP)-D, ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: HAND HYGIENE	0 510			

Minnesota Department of Health

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0 510	Continued From page 9 ULP-D was hired June 19, 2025, and provided direct patient care. On October 14, 2025, at 6:35 a.m., the surveyor observed ULP-D assisting R2 with medication administration. Without performing HH, ULP-D entered R2's room, removed medication bubble packs from a locked cabinet in the kitchen, punched out the medication from a bubble pack and placed it into a medication cup, gave the medication to R2 and put the pack back into the cabinet. Without performing HH, ULP-D left R2's room and walked down the hall to R6's room. Without performing HH, ULP-D entered R6's room, retrieved a pair of pants from R6's closet and assisted R6 to walk into the bathroom. Without performing HH, ULP-D gathered R6's toothbrush, placed toothpaste on the toothbrush and gave it to R6. While R6 brushed their teeth, ULP-D applied gloves and cleaned the front of R6's soiled toilet basin. ULP-D removed the gloves and waited for R6 to finish brushing their teeth. Without performing HH, ULP-D went to the kitchen and removed medication bubble packs from a locked cabinet. ULP-D punched out the medications from the bubble packs and placed them into a medication cup, gave the medication to R6 and put the packs back into the cabinet. Without performing HH, ULP-D left R6's room, walked down the hall and entered the nursing office. On October 14, 2025, at 10:10 a.m., ULP-D stated they had been trained by the RN on infection control. ULP-B further stated they should have performed HH between resident cares, but it was difficult because "unless you bring your own," hand sanitizer is not readily available in the memory care unit.	0 510			

Minnesota Department of Health

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0 510	Continued From page 10 CLEANING MEDICAL EQUIPMENT ULP-E was hired May 11, 2025, and provided direct patient care. On October 14, 2025, at 7:50 a.m., the surveyor observed ULP-E assisting R10 with an oxygen saturation reading. ULP-E gathered an oximeter (equipment used to check oxygen level) from a kitchen cabinet near the commons area. ULP-E brought the oximeter to the kitchen table where R10 was sitting. Without cleaning the equipment, ULP-E placed the oximeter on R10's left middle finger and obtained the oxygen level. ULP-E recorded the reading and removed the oximeter. ULP-E brought the oximeter back to the kitchen and without cleaning it, placed the oximeter back into the cabinet. On October 14, 2025, at 7:55 a.m., ULP-E stated they were trained by the RN on infection control. ULP-E stated they wipe down shared medical equipment "once a day," or more often if the resident is "sweaty." On October 14, 2025, at 10:15 a.m., clinical nurse supervisor (CNS)-B stated staff were trained to perform HH before administering medications, any time they wear gloves and before and after resident contact. CNS-B stated they were not sure why it was not done. CNS-B further stated the mechanical lift equipment (equipment used to assist with transfers) was scheduled to be cleaned every shift and the ULP may have thought the oximeter was cleaned the same way. The Centers for Disease Control and Prevention (CDC) guidance titled CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, dated April 12,	0 510			

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0 510	Continued From page 11 2024, indicated healthcare personnel (HCP) should perform HH immediately before touching a patient (resident), after touching a patient or the patient's immediate environment and immediately after glove removal. The guidance further indicated reusable point of care medical equipment such as blood pressure cuffs and oximeters should be cleaned and reprocessed (disinfected or sterilized) prior to use on another patient or when soiled. The licensee's Hand Hygiene (Based upon the CDC Guideline Hand Hygiene in Healthcare Settings) policy, dated August 2025, indicated hand hygiene would be performed immediately before touching a resident, after touching the resident or resident's immediate environment and immediately before putting on gloves and after glove removal. The licensee's undated Education: Clean and Safe Environment form indicated equipment that is reusable, and is used for more than one resident, needs to be disinfected to prevent the spread of infection. The form further indicated the equipment would be cleaned using an alcohol wipe after each use. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current	0 660			

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0 660	Continued From page 12 tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure screening for active TB (either by a two-step tuberculin skin test (TST) or a single interferon gamma release assay (IGRA) TB blood test) was completed and documented for one of three employees (unlicensed personnel (ULP)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 660			

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0 660	Continued From page 13 The licensee's TB facility risk assessment, dated April 18, 2025, indicated the facility was a "low" risk for TB transmission. ULP-F was hired August 19, 2024, and provided direct cares and services to residents. On October 14, 2025, at 8:03 a.m., the surveyor observed ULP-F assisting R4 with repositioning in bed. ULP-F's employee record contained an IGRA blood test, dated March 3, 2025, (196 days after the date of hire). On October 14, 2025, at 12:22 p.m., licensed assisted living director (LALD)-A stated around the first of the year they noticed some employees had incomplete TB testing, including ULP-F. LALD-A stated they had not documented the findings and just "told them to get one done." LALD-A further stated they were not sure why they were not done on time. The Minnesota Department of Health (MDH) guidelines, "Regulations for Tuberculosis Control in Minnesota Health Care Settings", dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include the following: a team responsible for TB infection control; a facility TB risk assessment; written TB infection control procedures; and HCW education. The guidelines also indicate an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST-tuberculin skin test (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB	0 660			

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0 660	Continued From page 14 screening should be documented in the employee's record. The licensee's TB Infection Control Plan policy, dated September 2021, indicated baseline testing would be completed prior to an employee providing direct care to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 980 SS=C	144G.51 ARBITRATION (a) An assisted living facility must clearly and conspicuously disclose, in writing in an assisted living contract, any arbitration provision in the contract that precludes, limits, or delays the ability of a resident from taking a civil action. (b) An arbitration requirement provision must not include a choice of law or choice of venue provision. Assisted living contracts must adhere to Minnesota law and any other applicable federal or local law. (c) An assisted living facility must not require any resident or the resident's representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include a choice of venue provision for arbitration one of one resident (R2). This practice resulted in a level one violation (a	0 980			

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0 980	Continued From page 15 violation that will cause only 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 the potential to affect a large portion or all the residents). The findings include: R2's service agreement, dated July 22, 2025, indicated R2 received services including assistance with bathing, grooming, transfers, and medication administration. R2's record included an arbitration agreement, signed July 21, 2025. The agreement contained the following language limiting the resident's choice of venue, "the arbitration will be conducted at a site selected by Facility which shall be either at Facility or somewhere within a reasonable distance of Facility that is convenient for both Facility and Resident." The agreement further indicated "any request to arbitrate a dispute must be submitted to AHLA (American Health Law Association) before two (2) years from the date the event giving rise to the dispute occurred. In the event AHLA is unable or unwilling to serve, then the request for Arbitration must be submitted to Facility within (30) thirty days of receiving AHLA 's notice of unwillingness or inability to serves as arbitrator." On October 14, 2025, at 12:22 p.m., licensed assisted living director (LALD)-A stated she was unaware the arbitration agreement contained incorrect language. LALD-A further stated they would let their leadership know. On October 15, 2025, at 9:35 a.m., LALD-A provide the surveyor with an updated arbitration	0 980			

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0 980	Continued From page 16 agreement form and stated it was the form currently being used by the licensee. LALD-A further stated they were "not sure why our marketing team wasn't using it." No further information was provided. TIME PERIOD OF CORRECTION: Twenty-one (21) days	0 980			
01620 SS=E	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	01620			

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01620	Continued From page 17 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 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 observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment 14 calendar days from the initiation of services for two of four residents (R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the	01620			

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01620	Continued From page 18 situation has occurred repeatedly; but is not found to be pervasive). The findings include: R4 R4 was admitted February 27, 2024. R4's service agreement, dated August 26, 2025, indicated R4 received services including assistance with medication administration. On October 14, 2025, at 8:03 a.m., the surveyor observed unlicensed personnel (ULP)-C and ULP-F assisting R4 with repositioning in bed. R4's record included an initial comprehensive nursing assessment, dated February 27, 2024, and a subsequent RN reassessment, dated March 22, 2024, completed 24 days (greater than 14 days) after the date services were initiated. R5 R5 was admitted November 12, 2024. R5's service agreement, dated July 11, 2025, indicated R5 received services including assistance with medication administration. On October 15, 2025, at 12:10 p.m., the surveyor observed R5 sitting at the dining room table watching television. R5's record included an initial comprehensive nursing assessment, dated November 12, 2024, and a subsequent RN reassessment, dated December 10, 2024, completed 28 days (greater than 14 days) after the date services were initiated.	01620			

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01620	Continued From page 19 On October 15, 2025, at 12:25 p.m., clinical nurse supervisor (CNS)-B stated it looked like R4 and R5's 14-day assessments were completed late. CNS-B further stated they did not see a progress note regarding when the 14-day assessments were completed so they were not sure why the assessments were not done on time. The licensee's Comprehensive Assessment Schedule, dated August 2022, indicated the RN would conduct a monitoring and reassessment within 14 days after the initiation of assisted living services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01640 SS=D	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 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	01640			

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01640	Continued From page 20 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 interview and record review, the licensee failed to finalize a current written service plan within 14 calendar days after the date services were first provided and further failed to include a signature or other authentication by the facility and by the resident or resident representative for one of four residents (R4). 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 was admitted February 28, 2024. On October 14, 2025, at 8:03 a.m., the surveyor observed unlicensed personnel (ULP)-C and ULP-F assisting R4 with repositioning in bed. R4's record included an unsigned service agreement, dated March 29, 2024, which indicated R4 received services including assistance with repositioning and medication administration. The service plan lacked authentication by R4 or R4's designated	01640			

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01640	Continued From page 21 representative and authentication by a facility representative documenting agreement on the services to be provided. On October 15, 2025, at 12:25 p.m., clinical nurse supervisor (CNS)-B stated they were unable to locate R4's signed service agreement and they were not sure where it could be. CNS-B further stated R4 was admitted before they started working for the licensee and they were not sure why the service agreement was not in R4's record. The licensee's Service Plan policy dated September 2023, indicated a finalized service plan would be completed within 14 days after initiation of services and would include a signature or authentication by the licensee and by the resident or resident representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the	01700			

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01700	Continued From page 22 resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. 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 face-to-face medication management assessment prior to providing medication management services for one of four 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: R2's service agreement, dated July 22, 2025, indicated R2 received services including	01700			

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01700	Continued From page 23 assistance with bathing, grooming, transfers, and medication administration. On October 14, 2025, at 6:35 a.m., the surveyor observed unlicensed personnel (ULP)-D assisting R2 with medication administration. R2's record included a medication administration record (MAR) for September 1, 2025, to October 13, 2025. The MAR indicated all of R2's medications were administered by the licensee's staff. R2's record included a change in condition nursing assessment dated July 22, 2025. The Medication and Treatment Evaluation and Management Plan section of the assessment indicated a face-to-face review of the medications was not completed, and that R2 managed and self-administer her own medications. R2's record lacked evidence the RN completed a face to face assessment of R2's medication management services to include: -an identification and review of all medications the resident is known to be taking, -indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues, and -identification of interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. On October 15, 2025, at 12:25 p.m., clinical nurse supervisor (CNS)-B stated it looked like the	01700			

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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
01700	Continued From page 24 medication management plan had not been updated when R2 moved to the licensee's secured dementia care unit. CNS-B stated he may not have saved the assessment before he "closed it," so the change did not get documented. The licensee's Medications & Treatments policy, dated March 2021, indicated a registered nurse would develop and maintain a current individualized medication management plan based on the resident's assessment. The policy further indicated the medication management plan would be completed with a change in condition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700			
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the	01910			

Minnesota Department of Health

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01910	Continued From page 25 medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include the medication strength, prescription number, quantity, date of disposition, and names of staff and other individuals involved in the disposition for one of three discharged 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 was admitted to the licensee on October 9, 2024, and discharged on July 24, 2025. R1's Discharge Assessment Tool summary, dated July 24, 2025, indicated R1 received services including, assistance with dressing, grooming, bathing, toileting and medication management. R1's record lacked documentation of medication disposition to include the medication's name, strength, prescription number as applicable, and	01910			

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01910	Continued From page 26 quantity. On October 14, 2025, at 10:15 a.m., clinical nurse supervisor (CNS)-B stated the licensee was working on getting everything into an electronic medical record system and there were a lot of papers to go through. CNS-B further stated they were unable to locate R1's medication disposition record. The licensee's Medication & Treatments policy, dated March 2021, indicated documentation of medication disposition would be kept in the resident record and would include the medication's name, strength, prescription number as applicable, quantity, to whom the medications were, given, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care,	02310	An immediate order was identified on October 14, 2025, for correction order 2310. The licensee provided an		

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02310	Continued From page 27 medical or nursing standards for one of three resident (R4) who utilized hospital style bed rails. 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 service plan, dated August 26, 2025, indicated R4 received services including assistance with turning, reposition, transfers and medication administration. On October 14, 2025, at 8:03 a.m., the surveyor observed R4 lying in a hospital-style bed with half bed rails on both sides of the upper part of the bed. The bed rails were firmly attached to the bed and were observed in the upright position. R4's record included a nursing assessment dated October 14, 2025. The physical device portion of the assessment indicated R4 utilized bilateral hospital-style half side bed rails for positioning. The assessment lacked documented measurements of the Food and Drug Administration (FDA)-identified zones of entrapment. On October 15, 2025, at 12:42 p.m., clinical nurse supervisor (CNS)-B stated the entrapment zone measurements for R4's bed rails were not listed in the assessment, and they were not sure why the measurements were missing.	02310	appropriate plan to mitigate the immediate risk. On December 11, 2025, the severity of the order was changed to a level 2; the correction timeframe was changed to 2 days.		

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02310	Continued From page 28 The FDA Guidance for Industry and FDA Staff Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated March 10, 2006, indicated Zone 1 is any open space within the perimeter of the rail. Openings in the rail should be small enough to prevent the head from entering. A loosened bar or rail can change the size of the space. The Hospital Bed Safety Workgroup (HBSW) and International Electrotechnical Commission (IEC) recommend that the space be less than 120 mm (4 ¾ inches), representing head breadth. Zone 2 is the space is the gap under the rail between a mattress compressed by the weight of a patient's head and the bottom edge of the rail at a location between the rail supports, or next to a single rail support. The FDA recommends that this space be small enough to prevent head entrapment, less than 120 mm (4 ¾ inches). Zone 3 is the space between the inside surface of the rail and the mattress compressed by the weight of a patient's head. The FDA recommends a dimensional limit of less than 120 mm (4 ¾ inches) for the area between the inside surface of the rail and the compressed mattress. Zone 4 is the gap that forms between the mattress compressed by the patient, and the lowermost portion of the rail, at the end of the rail. The FDA recommends that the dimensional limit for this space also be less than 60 mm (2 3/8 inches). The FDA's, A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement,	02310			

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02310	Continued From page 29 or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) indicated, " To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint. Additionally, the licensee must ensure the bed rail measurements are documented and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 4, 2025

Licensee
Round Lake Senior Living
1740 Parkshore Drive
Arden Hills, MN 55112

RE: Project Number(s) SL39081016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 16, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement;

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 5: a fine of \$5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed

pursuant to this survey:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - \$500.00

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

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

A handwritten signature in cursive script that reads "Renee L. Anderson".

Renee L. Anderson, Supervisor

State Evaluation Team

Email: Renee.L.Anderson@state.mn.us

Telephone: 651-201-5871 Fax: 1-866-890-9290

CLN

Minnesota Department of Health

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0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL #39081016-0 On October 13, 2025, through October 16, 2025, 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 120 residents, 84 of whom were receiving services under the provider's Assisted Living Facility 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 License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the 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 pursuant to 144G.31 Subd. 1, 2 and 3.		
0 130 SS=C	144G.12, Subd. 1 Application for Licensure Each application for an assisted living facility license, including provisional and renewal applications, must include information sufficient	0 130			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 130	Continued From page 1 to show that the applicant meets the requirements of licensure, including: (1) the business name and legal entity name of the licensee, and the street address and mailing address of the facility; (2) the names, e-mail addresses, telephone numbers, and mailing addresses of all owners, controlling individuals, managerial officials, and the assisted living director; (3) the name and e-mail address of the managing agent and manager, if applicable; (4) the licensed resident capacity and the license category; (5) the license fee in the amount specified in section 144.122; (6) documentation of compliance with the background study requirements in section 144G.13 for the owner, controlling individuals, and managerial officials. Each application for a new license must include documentation for the applicant and for each individual with five percent or more direct or indirect ownership in the applicant; (7) evidence of workers' compensation coverage as required by sections 176.181 and 176.182; (8) documentation that the facility has liability coverage; (9) a copy of the executed lease agreement between the landlord and the licensee, if applicable; (10) a copy of the management agreement, if applicable; (11) a copy of the operations transfer agreement or similar agreement, if applicable; (12) an organizational chart that identifies all organizations and individuals with an ownership interest in the licensee of five percent or greater and that specifies their relationship with the licensee and with each other;	0 130			

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0 130	Continued From page 2 (13) whether the applicant, owner, controlling individual, managerial official, or assisted living director of the facility has ever been convicted of: (i) a crime or found civilly liable for a federal or state felony level offense that was detrimental to the best interests of the facility and its resident within the last ten years preceding submission of the license application. Offenses include: felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; any felonies involving malpractice that resulted in a conviction of criminal neglect or misconduct; and any felonies that would result in a mandatory exclusion under section 1128(a) of the Social Security Act; (ii) any misdemeanor conviction, under federal or state law, related to: the delivery of an item or service under Medicaid or a state health care program, or the abuse or neglect of a patient in connection with the delivery of a health care item or service; (iii) any misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service; (iv) any felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in Code of Federal Regulations, title 42, section 1001.101 or 1001.201; (v) any felony or misdemeanor conviction, under	0 130			

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0 130	Continued From page 3 federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; (vi) any felony or gross misdemeanor that relates to the operation of a nursing home or assisted living facility or directly affects resident safety or care during that period; (vii) any revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority; (viii) any revocation or suspension of accreditation; or (ix) any suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or nonprocurement program; (14) whether, in the preceding three years, the applicant or any owner, controlling individual, managerial official, or assisted living director of the facility has a record of defaulting in the payment of money collected for others, including the discharge of debts through bankruptcy proceedings; (15) the signature of the owner of the licensee, or an authorized agent of the licensee; (16) identification of all states where the applicant or individual having a five percent or more ownership, currently or previously has been licensed as an owner or operator of a long-term care, community-based, or health care facility or agency where its license or federal certification has been denied, suspended, restricted, conditioned, refused, not renewed, or revoked under a private or state-controlled receivership, or where these same actions are pending under	0 130			

Minnesota Department of Health

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0 130	Continued From page 4 the laws of any state or federal authority; (17) statistical information required by the commissioner; and (18) any other information required by the commissioner. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to meet the requirements of licensure for the assisted living (AL) license they possessed. The license indicated a total capacity of 116, however there was potential for 120 residents. This practice resulted in a level one violation (a violation that will cause only 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 the potential to affect a large portion or all the residents). The findings include: The licensee's Application for Assisted Living License, signed by the licensee's assisted living director (LALD)-A on November 21, 2024, indicated the total licensed resident capacity for the current licensed period was 116. On October 13, 2025, at 12:45 p.m., the surveyor observed the licensee's Assisted Living License certificate in a picture frame located on a stand behind the reception desk. The certificate was for the current licensing period of January 6, 2025, to January 5, 2026, and indicated a capacity of 116.	0 130			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39081	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/16/2025
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0 130	Continued From page 5 On October 13, 2025, at 2:46 p.m., LALD-A stated via email, there were 84 residents receiving assisted living services and 36 independent living residents (a total of 120 residents). -at 2:55 p.m., LALD-A stated they did not know the capacity count included non-assisted residents and they would have to check with leadership because it was "not my area." On October 14, 2025, at 1:29 p.m., LALD-A stated the licensee had sent a request to increase the license capacity. LALD-A further stated the total number of residents originally given to the surveyor (120) included two people renting an apartment who had not moved in yet, and another resident who had just moved out. On October 15, 2025, at 11:02 a.m., LALD-A provided the surveyor the licensee's Licensed Resident Capacity Increase Request form, signed by authorized agent (AA)-I, dated October 13, 2025 (during the survey period). The form indicated the licensee requested the resident capacity be increased from 116 to 132. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 130			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed	0 480			

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0 480	Continued From page 6 capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb	0 480			

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0 480	Continued From page 7 breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 14, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 510 SS=F	144G.41 Subd. 3 Infection control program	0 510			

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0 510	Continued From page 8 (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b) The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control, which included ensuring direct care staff appropriately gloved and performed adequate hand hygiene (HH) and cleaned reusable point of care medical equipment, for 2 of 2 staff observed (unlicensed personnel (ULP)-D, ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 510			

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0 510	Continued From page 9 HAND HYGIENE ULP-D was hired June 19, 2025, and provided direct patient care. On October 14, 2025, at 6:35 a.m., the surveyor observed ULP-D assisting R2 with medication administration. Without performing HH, ULP-D entered R2's room, removed medication bubble packs from a locked cabinet in the kitchen, punched out the medication from a bubble pack and placed it into a medication cup, gave the medication to R2 and put the pack back into the cabinet. Without performing HH, ULP-D left R2's room and walked down the hall to R6's room. Without performing HH, ULP-D entered R6's room, retrieved a pair of pants from R6's closet and assisted R6 to walk into the bathroom. Without performing HH, ULP-D gathered R6's toothbrush, placed toothpaste on the toothbrush and gave it to R6. While R6 brushed their teeth, ULP-D applied gloves and cleaned the front of R6's soiled toilet basin. ULP-D removed the gloves and waited for R6 to finish brushing their teeth. Without performing HH, ULP-D went to the kitchen and removed medication bubble packs from a locked cabinet. ULP-D punched out the medications from the bubble packs and placed them into a medication cup, gave the medication to R6 and put the packs back into the cabinet. Without performing HH, ULP-D left R6's room, walked down the hall and entered the nursing office. On October 14, 2025, at 10:10 a.m., ULP-D stated they had been trained by the RN on infection control. ULP-B further stated they should have performed HH between resident cares, but it was difficult because "unless you	0 510			

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0 510	Continued From page 10 bring your own," hand sanitizer is not readily available in the memory care unit. CLEANING MEDICAL EQUIPMENT ULP-E was hired May 11, 2025, and provided direct patient care. On October 14, 2025, at 7:50 a.m., the surveyor observed ULP-E assisting R10 with an oxygen saturation reading.ULP-E gathered an oximeter (equipment used to check oxygen level) from a kitchen cabinet near the commons area. ULP-E brought the oximeter to the kitchen table where R10 was sitting. Without cleaning the equipment, ULP-E placed the oximeter on R10's left middle finger and obtained the oxygen level. ULP-E recorded the reading and removed the oximeter. ULP-E brought the oximeter back to the kitchen and without cleaning it, placed the oximeter back into the cabinet. On October 14, 2025, at 7:55 a.m., ULP-E stated they were trained by the RN on infection control. ULP-E stated they wipe down shared medical equipment "once a day," or more often if the resident is "sweaty." On October 14, 2025, at 10:15 a.m., clinical nurse supervisor (CNS)-B stated staff were trained to perform HH before administering medications, any time they wear gloves and before and after resident contact. CNS-B stated they were not sure why it was not done. CNS-B further stated the mechanical lift equipment (equipment used to assist with transfers) was scheduled to be cleaned every shift and the ULP may have thought the oximeter was cleaned the same way.	0 510			

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0 510	Continued From page 11 The Centers for Disease Control and Prevention (CDC) guidance titled CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, dated April 12, 2024, indicated healthcare personnel (HCP) should perform HH immediately before touching a patient (resident), after touching a patient or the patient's immediate environment and immediately after glove removal. The guidance further indicated reusable point of care medical equipment such as blood pressure cuffs and oximeters should be cleaned and reprocessed (disinfected or sterilized) prior to use on another patient or when soiled. The licensee's Hand Hygiene (Based upon the CDC Guideline Hand Hygiene in Healthcare Settings) policy, dated August 2025, indicated hand hygiene would be performed immediately before touching a resident, after touching the resident or resident's immediate environment and immediately before putting on gloves and after glove removal. The licensee's undated Education: Clean and Safe Environment form indicated equipment that is reusable, and is used for more than one resident, needs to be disinfected to prevent the spread of infection. The form further indicated the equipment would be cleaned using an alcohol wipe after each use. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control	0 660			

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0 660	Continued From page 12 (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure screening for active TB (either by a two-step tuberculin skin test (TST) or a single interferon gamma release assay (IGRA) TB blood test) was completed and documented for one of three employees (unlicensed personnel (ULP)-F). 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	0 660			

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0 660	Continued From page 13 failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's TB facility risk assessment, dated April 18, 2025, indicated the facility was a "low" risk for TB transmission. ULP-F was hired August 19, 2024, and provided direct cares and services to residents. On October 14, 2025, at 8:03 a.m., the surveyor observed ULP-F assisting R4 with repositioning in bed. ULP-F's employee record contained an IGRA blood test, dated March 3, 2025, (196 days after the date of hire). On October 14, 2025, at 12:22 p.m., licensed assisted living director (LALD)-A stated around the first of the year they noticed some employees had incomplete TB testing, including ULP-F. LALD-A stated they had not documented the findings and just "told them to get one done." LALD-A further stated they were not sure why they were not done on time. The Minnesota Department of Health (MDH) guidelines, "Regulations for Tuberculosis Control in Minnesota Health Care Settings", dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include the following: a team responsible for TB infection control; a facility TB risk assessment; written TB infection control procedures; and HCW education. The guidelines also indicate an employee may begin working with patients after a	0 660			

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0 660	Continued From page 14 negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST-tuberculin skin test (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employee's record. The licensee's TB Infection Control Plan policy, dated September 2021, indicated baseline testing would be completed prior to an employee providing direct care to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 980 SS=C	144G.51 ARBITRATION (a) An assisted living facility must clearly and conspicuously disclose, in writing in an assisted living contract, any arbitration provision in the contract that precludes, limits, or delays the ability of a resident from taking a civil action. (b) An arbitration requirement provision must not include a choice of law or choice of venue provision. Assisted living contracts must adhere to Minnesota law and any other applicable federal or local law. (c) An assisted living facility must not require any resident or the resident's representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. This MN Requirement is not met as evidenced by:	0 980			

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0 980	Continued From page 15 Based on interview and record review, the licensee failed to ensure the assisted living contract did not include a choice of venue provision for arbitration one of one resident (R2). This practice resulted in a level one violation (a violation that will cause only 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 the potential to affect a large portion or all the residents). The findings include: R2's service agreement, dated July 22, 2025, indicated R2 received services including assistance with bathing, grooming, transfers, and medication administration. R2's record included an arbitration agreement, signed July 21, 2025. The agreement contained the following language limiting the resident's choice of venue, "the arbitration will be conducted at a site selected by Facility which shall be either at Facility or somewhere within a reasonable distance of Facility that is convenient for both Facility and Resident." The agreement further indicated "any request to arbitrate a dispute must be submitted to AHLA (American Health Law Association) before two (2) years from the date the event giving rise to the dispute occurred. In the event AHLA is unable or unwilling to serve, then the request for Arbitration must be submitted to Facility within (30) thirty days of receiving AHLA 's notice of unwillingness or inability to serves as arbitrator." On October 14, 2025, at 12:22 p.m., licensed	0 980			

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0 980	Continued From page 16 assisted living director (LALD)-A stated she was unaware the arbitration agreement contained incorrect language. LALD-A further stated they would let their leadership know. On October 15, 2025, at 9:35 a.m., LALD-A provide the surveyor with an updated arbitration agreement form and stated it was the form currently being used by the licensee. LALD-A further stated they were "not sure why our marketing team wasn't using it." No further information was provided. TIME PERIOD OF CORRECTION: Twenty-one (21) days	0 980			
01620 SS=E	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	01620			

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01620	Continued From page 17 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 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 observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment 14 calendar days from the initiation of services for two of four residents (R4, R5).	01620			

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01620	Continued From page 18 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R4 R4 was admitted February 27, 2024. R4's service agreement, dated August 26, 2025, indicated R4 received services including assistance with medication administration. On October 14, 2025, at 8:03 a.m., the surveyor observed unlicensed personnel (ULP)-C and ULP-F assisting R4 with repositioning in bed. R4's record included an initial comprehensive nursing assessment, dated February 27, 2024, and a subsequent RN reassessment, dated March 22, 2024, completed 24 days (greater than 14 days) after the date services were initiated. R5 R5 was admitted November 12, 2024. R5's service agreement, dated July 11, 2025, indicated R5 received services including assistance with medication administration. On October 15, 2025, at 12:10 p.m., the surveyor	01620			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39081	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/16/2025
NAME OF PROVIDER OR SUPPLIER ROUND LAKE SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 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
01620	Continued From page 19 observed R5 sitting at the dining room table watching television. R5's record included an initial comprehensive nursing assessment, dated November 12, 2024, and a subsequent RN reassessment, dated December 10, 2024, completed 28 days (greater than 14 days) after the date services were initiated. On October 15, 2025, at 12:25 p.m., clinical nurse supervisor (CNS)-B stated it looked like R4 and R5's 14-day assessments were completed late. CNS-B further stated they did not see a progress note regarding when the 14-day assessments were completed so they were not sure why the assessments were not done on time. The licensee's Comprehensive Assessment Schedule, dated August 2022, indicated the RN would conduct a monitoring and reassessment within 14 days after the initiation of assisted living services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01640 SS=D	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	01640			

Minnesota Department of Health

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01640	Continued From page 20 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 interview and record review, the licensee failed to finalize a current written service plan within 14 calendar days after the date services were first provided and further failed to include a signature or other authentication by the facility and by the resident or resident representative for one of four residents (R4). 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:	01640			

Minnesota Department of Health

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01640	Continued From page 21 R4 was admitted February 28, 2024. On October 14, 2025, at 8:03 a.m., the surveyor observed unlicensed personnel (ULP)-C and ULP-F assisting R4 with repositioning in bed. R4's record included an unsigned service agreement, dated March 29, 2024, which indicated R4 received services including assistance with repositioning and medication administration. The service plan lacked authentication by R4 or R4's designated representative and authentication by a facility representative documenting agreement on the services to be provided. On October 15, 2025, at 12:25 p.m., clinical nurse supervisor (CNS)-B stated they were unable to locate R4's signed service agreement and they were not sure where it could be. CNS-B further stated R4 was admitted before they started working for the licensee and they were not sure why the service agreement was not in R4's record. The licensee's Service Plan policy dated September 2023, indicated a finalized service plan would be completed within 14 days after initiation of services and would include a signature or authentication by the licensee and by the resident or resident representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			

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01700	Continued From page 22	01700			
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. 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 face-to-face medication management assessment prior to providing medication management services for one of four residents (R2).	01700			

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01700	Continued From page 23 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2's service agreement, dated July 22, 2025, indicated R2 received services including assistance with bathing, grooming, transfers, and medication administration. On October 14, 2025, at 6:35 a.m., the surveyor observed unlicensed personnel (ULP)-D assisting R2 with medication administration. R2's record included a medication administration record (MAR) for September 1, 2025, to October 13, 2025. The MAR indicated all of R2's medications were administered by the licensee's staff. R2's record included a change in condition nursing assessment dated July 22, 2025. The Medication and Treatment Evaluation and Management Plan section of the assessment indicated a face-to-face review of the medications was not completed, and that R2 managed and self-administer her own medications. R2's record lacked evidence the RN completed a face to face assessment of R2's medication	01700			

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01700	Continued From page 24 management services to include: -an identification and review of all medications the resident is known to be taking, -indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues, and -identification of interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. On October 15, 2025, at 12:25 p.m., clinical nurse supervisor (CNS)-B stated it looked like the medication management plan had not been updated when R2 moved to the licensee's secured dementia care unit. CNS-B stated he may not have saved the assessment before he "closed it," so the change did not get documented. The licensee's Medications & Treatments policy, dated March 2021, indicated a registered nurse would develop and maintain a current individualized medication management plan based on the resident's assessment. The policy further indicated the medication management plan would be completed with a change in condition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700			

Minnesota Department of Health

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01910	Continued From page 25	01910			
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include the medication strength, prescription number, quantity, date of disposition, and names of staff and other individuals involved in the disposition for one of three discharged 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	01910			

Minnesota Department of Health

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01910	Continued From page 26 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 was admitted to the licensee on October 9, 2024, and discharged on July 24, 2025. R1's Discharge Assessment Tool summary, dated July 24, 2025, indicated R1 received services including, assistance with dressing, grooming, bathing, toileting and medication management. R1's record lacked documentation of medication disposition to include the medication's name, strength, prescription number as applicable, and quantity. On October 14, 2025, at 10:15 a.m., clinical nurse supervisor (CNS)-B stated the licensee was working on getting everything into an electronic medical record system and there were a lot of papers to go through. CNS-B further stated they were unable to locate R1's medication disposition record. The licensee's Medication & Treatments policy, dated March 2021, indicated documentation of medication disposition would be kept in the resident record and would include the medication's name, strength, prescription number as applicable, quantity, to whom the medications were, given, date of disposition, and names of staff and other individuals involved in the disposition.	01910			

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01910	Continued From page 27 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for one of three resident (R4) who utilized hospital style bed rails. 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: R4's service plan, dated August 26, 2025, indicated R4 received services including assistance with turning, reposition, transfers and medication administration.	02310			

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02310	Continued From page 28 On October 14, 2025, at 8:03 a.m., the surveyor observed R4 lying in a hospital-style bed with half bed rails on both sides of the upper part of the bed. The bed rails were firmly attached to the bed and were observed in the upright position. R4's record included a nursing assessment dated October 14, 2025. The physical device portion of the assessment indicated R4 utilized bilateral hospital-style half side bed rails for positioning. The assessment lacked documented measurements of the Food and Drug Administration (FDA)-identified zones of entrapment. On October 15, 2025, at 12:42 p.m., clinical nurse supervisor (CNS)-B stated the entrapment zone measurements for R4's bed rails were not listed in the assessment, and they were not sure why the measurements were missing. The FDA Guidance for Industry and FDA Staff Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated March 10, 2006, indicated Zone 1 is any open space within the perimeter of the rail. Openings in the rail should be small enough to prevent the head from entering. A loosened bar or rail can change the size of the space. The Hospital Bed Safety Workgroup (HBSW) and International Electrotechnical Commission (IEC) recommend that the space be less than 120 mm (4 ¾ inches), representing head breadth. Zone 2 is the space is the gap under the rail between a mattress compressed by the weight of a patient's head and the bottom edge of the rail at a location between the rail supports, or next to a single rail support. The FDA recommends that this space be small enough to prevent head entrapment,	02310			

Minnesota Department of Health

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02310	Continued From page 29 less than 120 mm (4 ¾ inches). Zone 3 is the space between the inside surface of the rail and the mattress compressed by the weight of a patient's head. The FDA recommends a dimensional limit of less than 120 mm (4 ¾ inches) for the area between the inside surface of the rail and the compressed mattress. Zone 4 is the gap that forms between the mattress compressed by the patient, and the lowermost portion of the rail, at the end of the rail. The FDA recommends that the dimensional limit for this space also be less than 60 mm (2 3/8 inches). The FDA's, A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) indicated, " To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or	02310			

Minnesota Department of Health

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02310	Continued From page 30 ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint. Additionally, the licensee must ensure the bed rail measurements are documented and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310			



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

Food & Beverage Inspection Report

Page: 1

Establishment Info

ROUND LAKE SENIOR LIVING
1740 PARKSHORE DRIVE
Arden Hills, MN 55112
Ramsey County
Parcel:

Phone:

License Info

License: HFID 39081

Risk:
License:
Expires on:
CFPM: Samuel Cavallaro
CFPM #: 122912; Exp: 4/18/2027

Inspection Info

Report Number: F1043251233
Inspection Type: Full - Single
Date: 10/14/2025 Time: 3:01:26 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 2
Total Priority 2 Orders: 1
Total Priority 3 Orders: 2
Delivery:

! New Order: 3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) Priority Level: Priority 1 CFP#: 15

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

COMMENT: FACILITY USES PASTEURIZED EGGS. RAW SHELL EGGS STORED OVER CHEESE AND DAIRY PRODUCTS IN BOTTOM PORTION OF PREP COOLER. ADVISED STAFF TO STORE RAW FOODS BELOW READY-TO-EAT FOODS. CORRECTED ONSITE. COMPLY WITH ABOVE RULE.

Comply By: 10/14/2025 Originally Issued On: 10/14/2025

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers

3-304.14B Priority Level: Priority 3 CFP#: 41

MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.

COMMENT: FACILITY USES QUATERNARY AMMONIA. SANI BUCKET MEASURED 0 PPM. ADVISED STAFF TO MAINTAIN CONCENTRATION BETWEEN 200-400 PPM. COMPLY WITH ABOVE RULE.

Comply By: 10/14/2025 Originally Issued On: 10/14/2025

New Order: 4-300 Equipment Numbers and Capacities

4-302.13B Priority Level: Priority 2 CFP#: 48

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

COMMENT: NO TEST KIT AVAILABLE FOR DISH MACHINE. ADVISED STAFF TO PROVIDE AN IRREVERSIBLE THERMOMETER OR THERMOLABELS TO MEASURE UTENSIL SURFACE TEMPERATURE OF AT LEAST 160F WEEKLY. COMPLY WITH ABOVE RULE.

Comply By: 10/14/2025 Originally Issued On: 10/14/2025

! New Order: 4-500 Equipment Maintenance and Operation

4-501.114C3 Priority Level: Priority 1 CFP#: 16

MN Rule 4626.0805C3 Provide and maintain an approved quaternary ammonium compound sanitizing solution in water with 500 ppm hardness or less, a minimum temperature of 75 degrees F (24 degrees C) and a concentration specified in 21CFR.178.1010 and as indicated by the manufacturer's use directions and label.

COMMENT: 3 COMP SINK DISPENSER MEASURED 150 PPM AND SANI SPRAY BOTTLE MEASURED 50 PPM. ADVISED STAFF TO MANUALLY MIX SANITIZER TO MEASURE BETWEEN 200-400 PPM UNTIL DISPENSER IS SERVICED. COMPLY WITH ABOVE RULE.

Comply By: 10/14/2025 Originally Issued On: 10/14/2025

New Order: 4-500 Equipment Maintenance and Operation

4-501.11AB *Priority Level: Priority 3 CFP#: 47*

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

COMMENT: (1) FACILITY USES QUATERNARY AMMONIA. 3 COMP SANI DISPENSER MEASURED 150 PPM.

ADVISED STAFF TO SERVICE DISPENSER TO MEASURE BETWEEN 200-400 PPM.

(2) ICE MACHINE IN NEED OF REPAIR. PER STAFF, REPAIRS ARE IN PROGRESS.

COMPLY WITH ABOVE RULE.

Comply By: 10/14/2025 Originally Issued On: 10/14/2025

Food & Beverage General Comment

Inspection was completed with Tammy Carlson as the lead Health Regulation Division Nurse Evaluator completing the site survey.

Discussed highly susceptible populations, date marking, illness policy, sanitizer use, ware washing, temperature control, cleaning, pest control, vomit/fecal procedures, test kits, food storage, and food handling procedures.

TEMPERATURE (F)

PREP COOLER: LETTUCE 41, TOMATO 41, HAM 41, HARD BOILED EGG 41

COLD DRAWER: CHICKEN 41, BEEF PATTY 41

SOUP WELL: SOUP 139

SERVER STATION REACH IN COOLER: CUT MELON 41, MILK 41, POTATO SALAD 41

WALK IN COOLER: SOUP 41, BEEF 41, CUT MELON 41

UTENSIL SURFACE TEMPERATURE (F)

DISH MACHINE: 165

QUATERNARY AMMONIA (PPM)\

3 COMP SANI DISPENSER: 150*

SANI BUCKET: 0*

SANI SPRAY BOTTLE: 50*

Contact Health Regulation Division for plan review approval when facility/kitchen undergoes remodeling, major equipment additions, or changes of equipment due to a menu change.

If any customer complains of illness, establishment is required to notify the Minnesota Department of Health and provide the foodborne illness hotline phone number to the customer: 1-877-366-3455

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 F1043251233 from 10/14/2025

Sam Cavallaro
Culinary Director


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