



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 5, 2026

Licensee
Shoreview Senior Living LLC
4710 Cumberland Street
Shoreview, MN 55126

RE: Project Number(s) SL28875017

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 13, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility.**

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>

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,



Renee Anderson, Supervisor

State Evaluation Team

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

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

KKM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28875	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/13/2026
NAME OF PROVIDER OR SUPPLIER SHOREVIEW SENIOR LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 4710 CUMBERLAND STREET SHOREVIEW, MN 55126		
(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 #28875017-0 On May 11, 2026, through May 13, 2026, 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 141 residents, 53 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.		
0 480 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	0 480			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28875	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/13/2026
NAME OF PROVIDER OR SUPPLIER SHOREVIEW SENIOR LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 4710 CUMBERLAND STREET SHOREVIEW, MN 55126		
(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
0 480	Continued From page 1 4626. (b) For an assisted living facility with a licensed 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	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28875	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/13/2026
NAME OF PROVIDER OR SUPPLIER SHOREVIEW SENIOR LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4710 CUMBERLAND STREET SHOREVIEW, MN 55126			
(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
0 480	Continued From page 2 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb 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, 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated May 12, 2026, 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			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28875	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/13/2026
NAME OF PROVIDER OR SUPPLIER SHOREVIEW SENIOR LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 4710 CUMBERLAND STREET SHOREVIEW, MN 55126		
(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
01060	Continued From page 3	01060			
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28875	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/13/2026
NAME OF PROVIDER OR SUPPLIER SHOREVIEW SENIOR LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4710 CUMBERLAND STREET SHOREVIEW, MN 55126			
(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
01060	Continued From page 4 returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide the resident or their representative with a written notice after an emergency relocation for one of one resident (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 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: R5's service plan, dated December 2, 2025, indicated R5 received services including assistance with medication administration. On May 12, 2026, at 8:05 a.m., unlicensed personnel (ULP)-C was observed assisting R5 with medication administration. R5's progress note dated November 17, 2025, at 3:51 p.m., indicated R5 was sent to the hospital on November 13, 2025, due to a possible wound infection, and returned to the facility November 17, 2025.	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28875	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/13/2026
NAME OF PROVIDER OR SUPPLIER SHOREVIEW SENIOR LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 4710 CUMBERLAND STREET SHOREVIEW, MN 55126		
(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
01060	Continued From page 5 R5's record lacked documentation a notice was provided to the resident, or their legal representative, with the following required content: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. On May 13, 2026, at 10:10 a.m., registered nurse (RN)-E stated R5 was hospitalized in November 2025, and an emergency relocation notification had not been provided to the resident or resident representative. RN-E stated they missed that requirement. The licensee's 1.22 Emergency Relocation policy, dated August 1, 2021, indicated a written notice with the required content would be provided to the resident and legal representative in the case of an emergency relocation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28875	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/13/2026
NAME OF PROVIDER OR SUPPLIER SHOREVIEW SENIOR LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4710 CUMBERLAND STREET SHOREVIEW, MN 55126			
(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
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for one of four residents (R5). This practice resulted in a level two violation (a	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28875	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/13/2026
NAME OF PROVIDER OR SUPPLIER SHOREVIEW SENIOR LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 4710 CUMBERLAND STREET SHOREVIEW, MN 55126		
(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
01650	Continued From page 7 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: R5 was admitted June 24, 2021, and had diagnoses including multiple sclerosis (an autoimmune disease the affects the central nervous system resulting in a range of physical and cognitive symptoms) and Type 2 diabetes. On May 12, 2026, at 8:05 a.m., the surveyor observed unlicensed personnel (ULP)-C assisting R5 applying knee-high pressure relief boots (used to provide wound protection and prevent pressure sores) to R5's right and left lower legs. R5's Service Plan dated May 13, 2026, indicated R5 received services including assistance with an AFO brace (ankle-foot orthotic-a brace that wraps around your lower leg, ankle, and foot to support walking and standing) to the right foot. R5's service plan did not include assistance with knee-high pressure relief boots applied to the right and left legs. R5's service plan lacked: -a description of the service to be provided, and the frequency of each service, according to the resident's current assessment and resident preferences, -the identification of staff or categories of staff who would provide the service. On May 13, 2026, at 10:20 a.m. the surveyor and clinical nurse supervisor (CNS)-B observed the	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28875	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/13/2026
NAME OF PROVIDER OR SUPPLIER SHOREVIEW SENIOR LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 4710 CUMBERLAND STREET SHOREVIEW, MN 55126		
(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
01650	Continued From page 8 boots that had been applied to R5's left and right lower legs. CNS-B stated they were not aware R5 was now using pressure relief boots on both lower legs and stated they thought R5 was still using the AFO boot. CNS-B further stated R5 had a home care nurse who may have supplied R5 with the pressure relief boots. On May 13, 2026, at 12:15 p.m., registered nurse (RN)-E stated R5 previously had an ACO boot when he was still walking. RN-E further stated R5 had an amputation in November, and the AFO boot should have been removed from the service plan at that time. The licensee's 6.08 Service Plan policy dated August 1, 2021, included, 9. A service plan will include: a. A description of the services that are to be provided based on the most recent assessment and resident preferences; b. Fees for services to be provided; c. The frequency of each service to be provided based on the most recent assessment and resident preferences; d. An identification of staff or categories of staff who will be providing services (RN, LPN, unlicensed personnel, etc.); No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28875	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/13/2026
NAME OF PROVIDER OR SUPPLIER SHOREVIEW SENIOR LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 4710 CUMBERLAND STREET SHOREVIEW, MN 55126		
(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
01760	Continued From page 9 resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as prescribed, or document why the medication was not administered as prescribed, for one of five residents (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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on May 11, 2026, at 10:30 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management to residents at the facility. R5's diagnoses included dementia.	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28875	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/13/2026
NAME OF PROVIDER OR SUPPLIER SHOREVIEW SENIOR LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 4710 CUMBERLAND STREET SHOREVIEW, MN 55126		
(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
01760	Continued From page 10 R5's Service Plan printed May 13, 2026, indicated R5's services included assistance with medication administration. R5's prescriber orders dated January 5, 2026, included an order for Lidocaine 4% patch on in AM (morning), off at HS (bedtime), apply to left shoulder for pain. R5's Medication Sheet documentation dated April 2026, and May 2026, indicated R5 was administered a Lidocaine 4% patch to the left shoulder, on in the AM and off at HS, daily. On May 12, 2026, at 8:05 a.m., the surveyor observed ULP-C retrieve a lidocaine 4% patch from R5's locked kitchen cabinet. ULP-C reviewed R5's medication sheet which included Lidocaine 4% patch with instructions to apply the patch to R5's left shoulder. ULP-C brought the patch to R5 who was lying in bed and applied the patch to R5's lower middle back. On May 12, 2026, at 2:00 p.m., the surveyor reviewed R5's MAR with ULP-C. ULP-C stated they put the lidocaine patch on the middle of R5's lower back and not on R5's left shoulder. ULP-C stated they were told by "the nurse" that the patch could be applied to either shoulder or the lower back. On 12, 2026, at 2:55 p.m., registered nurse (RN)-E stated the provider order indicated the lidocaine patch should be applied to the left shoulder. RN-E further stated R5's wife was a nurse and may have told the ULP they could apply the patch to R5's lower back. The licensee's 7.14 Medication and Treatment-Administration and Delegation policy dated	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28875	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/13/2026
NAME OF PROVIDER OR SUPPLIER SHOREVIEW SENIOR LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 4710 CUMBERLAND STREET SHOREVIEW, MN 55126		
(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
01760	Continued From page 11 August 1, 2021, indicated an RN (registered nurse) must specify, in writing, specific instructions for each resident and document those instructions in the residents' record. In addition, the ULP must demonstrate their ability to competently follow the delegated medication administration to a RN. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
02280 SS=C	144G.90 Subd. 5 Notice to residents; change in ownership or m (a) A facility must provide written notice to the resident, legal representative, or designated representative of a change of ownership within seven calendar days after the facility receives a new license. (b) A facility must provide prompt written notice to the resident, legal representative, or designated representative, of any change of legal name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the manager of the facility, if applicable; and (2) the authorized agent. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide written notice to the residents, legal representative, or designated representative of a change of ownership (CHOW), with all required content. This had the potential to affect all residents residing at the assisted living facility.	02280			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28875	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/13/2026
NAME OF PROVIDER OR SUPPLIER SHOREVIEW SENIOR LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 4710 CUMBERLAND STREET SHOREVIEW, MN 55126		
(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
02280	Continued From page 12 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 potential to affect a large portion or all of the residents). The findings include: During the entrance conference on May 11, 2026, at 10:30 a.m., vice president of clinical operations (VPCO)-F stated the licensee was familiar with current minimum assisted living requirements. The licensee submitted a CHOW application, signed December 11, 2025. The licensee indicated the CHOW would be effective as of December 1, 2025. The Department sent an email to the licensee on January 28, 2026, that confirmed the licensee's CHOW was completed. The email indicated the CHOW was effective August 29, 2025 through August 28, 2026. On May 13, 2026, at 9:30 a.m., VPCO-F stated the licensee had not provided written notice to the residents, legal representative, or designated representative of CHOW, and they did not realize they needed to. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02280			



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

Shoreview Senior Living LLC
4710 Cumberland Street
Shoreview, MN 55126
Ramsey County
Parcel:

Phone:

License Info

License: HFID 28875

Risk:
License:
Expires on:
CFPM: Mark Hall
CFPM #: FM14276FM8524; Exp:
11/10/2028

Inspection Info

Report Number: F1025261101
Inspection Type: Full - Single
Date: 5/12/2026 Time: 11:30 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery:

New Order: 4-200 Equipment Design and Construction

4-201.11AMN Priority Level: Priority 3 CFP#: 47

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

COMMENT: Milk cold holding in both Memory Care neighborhood kitchen refrigerators, hot resident meal cooling in one Memory Care refrigerator. Both refrigerators are residential (do not meet the above standard). Discontinue cooling TCS food in the refrigerators. Maintain all cold TCS foods in refrigerator at 41 deg F. If refrigerators do not hold cold TCS foods at 41 deg F or below, or will be used for cooling TCS foods, replace with a cooler which meets the above standards.

Comply By: 5/12/2026 Originally Issued On: 5/12/2026

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 F1025261101 from 5/12/2026

Jon, Mark


Casey Kipping, MA RS
Public Health Sanitarian 3
651-201-4513
casey.kipping@state.mn.us



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

Temperature Observations/Recordings

Page: 1

Establishment Info

Shoreview Senior Living LLC
Shoreview
County/Group: Ramsey County

Inspection Info

Report Number: F1025261101
Inspection Type: Full
Date: 5/12/2026
Time: 11:30 AM

Food Temperature: **Product/Item/Unit:** Wild rice; **Temperature Process:** Cold holding

Location: Walk-in cooler at 40 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Cooked onion; **Temperature Process:** Hot holding

Location: Serving line at 170 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Soup; **Temperature Process:** Hot holding

Location: Heat and serve at 155 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Dressing; **Temperature Process:** Cold holding

Location: Upright expo cooler at 41 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Milk; **Temperature Process:** Cold holding

Location: Memory care neighborhood kitchen 1 at 41 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Milk; **Temperature Process:** Cold holding

Location: Memory care neighborhood kitchen 2 at 41 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Milk; **Temperature Process:** Cooling from ambient

Location: Dining area drink cooler at 45 Degrees F.

Comment: Discussed maintaining milk in the kitchen cooler and using the merchandizing cooler only for juice

Violation Issued?: No



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

Sanitizer Observations/Recordings

Page: 1

Establishment Info

Shoreview Senior Living LLC
Shoreview
County/Group: Ramsey County

Inspection Info

Report Number: F1025261101
Inspection Type: Full
Date: 5/12/2026
Time: 11:30 AM

Sanitizing Equipment: Product: Dish machine; **Sanitizing Process:** High temperature

Location: Dishwashing area **Equal To** 164 Degrees F.

Comment: Est TMD within 2 deg F

Wash 160 F

Rinse 180 F

Contact 164, 166 F

Rinse PSI 14, monitor and service dish machine if needed

Violation Issued?: No

Minnesota (MDH) Version EH Manager; RPT: F1025261101		Food Establishment Inspection Report		Page 1 of 1		
 Metro District Office Minnesota Department of Health 625 Robert St N, PO BOX 64975 St Paul, MN 55164		No. of Risk Factor/Intervention/Violations		0	Date: 5/12/2026	
		No. of Repeat Risk Factor/Intervention/Violations			Time: 11:30 AM	
		Score (optional)			Dur: min	
Establishment: Shoreview Senior Living LLC		Address: 4710 Cumberland Street		City/State: Shoreview, MN	Zip: 55126	Phone:
License/Permit #: HFID 28875		Permit Holder:		Purpose of Inspection: Full	Est. Type:	Risk Category:
FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS						
Designated compliance status (IN, OUT, N/O, N/A) for each numbered item						
IN=in compliance OUT=not in compliance N/O=not observed N/A=not applicable						
Mark "X" in appropriate box for COS and/or R						
COS=corrected on-site during inspection R=repeat violation						
Compliance Status				COS	R	
Supervision						
1	IN	Person in charge present, demonstrate knowledge and performs duties				
2	IN	Certified Food Protection Manager				
Employee Health						
3	IN	knowledge, responsibilities, and reporting				
4	IN	Proper use of restriction and exclusion				
5	IN	Response to vomiting, diarrheal events				
Good Hygienic Practices						
6	IN	Proper eating, tasting, drinking, tobacco use				
7	IN	No discharge from eyes, nose, and mouth				
Preventing Contamination by Hands						
8	IN	Hands clean and properly washed				
9	IN	No bare hand contact with RTE foods, alternatives				
10	IN	Adequate handwashing sinks supplied and access				
Approved Source						
11	IN	Food obtained from approved source				
12	N/O	Food Received at proper temperature				
13	IN	Food in good condition, safe & unadulterated				
14	N/A	Records available: shellstock tags, parasite dest.				
Protection From Contamination						
15	IN	Food separated and protected				
16	IN	Food-contact surfaces; cleaned & sanitized				
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food				
GOOD RETAIL PRACTICES						
Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.						
Mark "X" or OUT in box if numbered item is not in compliance Mark "X" in appropriate box for COS and/or R COS=corrected on-site during inspection R=repeat violation						
Compliance Status				COS	R	
Safe Food and Water						
30	IN	Pasteurized eggs used where required				
31		Water & ice from approved source				
32	N/A	Variance obtained for specialized processing methods				
Food Temperature Control						
33		Proper cooling methods used; adequate equipment for temperature control				
34	N/O	Plant food properly cooked for hot holding				
35	IN	Approved thawing methods used				
36		Thermometers provided & accurate				
Food Identification						
37		Food properly labeled; original container				
Prevention of Food Contamination						
38		Insects, rodents, & animals not present; no unauthorized person				
39		Contamination prevented during food prep, storage, & display				
40		Personal cleanliness				
41		Wiping cloths: properly used & stored				
42		Washing fruits & vegetables				
Person in Charge (signature)						
Inspector (signature)						
Follow-up: Follow-up Date:						
Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health interventions are control measures to prevent foodborne illness or injury						
Proper Use of Utensils						
43		In-use utensils; Properly stored				
44		Utensils, equipment & linens; properly stored, dried, handled				
45		Single-use & single-service articles, properly stored and used				
46		Gloves used properly				
Utensils, Equipment and Vending						
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used				
48		Warewashing facilities: installed, maintained, used; test strips				
49		Non-food contact surfaces clean				
Physical Facilities						
50		Hot & cold water available; adequate pressure				
51		Plumbing installed; proper backflow devices				
52		Sewage & waste water properly disposed				
53		Toilet facilities; properly constructed, supplied & cleaned				
54		Garbage & refuse properly disposed; facilities maintained				
55		Physical facilities installed, maintained & clean				
56		Adequate ventilation & lighting; designated areas used				
57		Compliance with MCIAA				
58		Compliance with licensing and plan review				