



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 6, 2025

Licensee
Mounds Home
7780 Long Lake Road
Mounds View, MN 55112

RE: Project Number(s) SL38979016

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.

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 . . ."

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 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$500.00
St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - \$500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,000.00**. 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 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

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38979	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/16/2025
NAME OF PROVIDER OR SUPPLIER MOUNDS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 7780 LONG LAKE ROAD MOUNDS VIEW, 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: SL38979016-0 On October 13, 2025, through October 16, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 5 residents; 5 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control	0 660			

Minnesota Department of Health

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

TITLE

(X6) DATE

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0 660	Continued From page 1 (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 interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), to include history and symptoms screening for active TB completed upon hire for one of two employees (unlicensed personnel (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 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).	0 660			

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0 660	Continued From page 2 The findings include: ULP-E was hired on September 28, 2025, and provided direct care services to the residents of the facility. ULP-E's employee record lacked documentation of a TB history and symptom screen completed upon hire. On October 14, 2025, at 11:00 a.m., clinical nurse supervisor (CNS)-B stated they were aware they needed to have a completed TB history and symptom screen for employees, prior to providing care to residents and it was an oversight that ULP-E's was not completed. The licensee's Tuberculosis Screening Policy dated August 13, 2025, indicated, "Staff whose essential job functions require work within the same air space of home care clients will be screened and tested for tuberculosis prior to the staff being exposed to clients. Baseline (upon hire) screening will be completed..." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced	0 775			

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0 775	Continued From page 3 by: Based on observation and interview, the licensee failed to maintain facility in compliance with Minnesota State Fire Code under Minnesota Rules Chapter 7511. This had the potential to affect all residents, staff, and visitors. 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: On October 15, 2025, from approximately 12:45 p.m. to 2:00 p.m., the surveyor toured the facility with house manager/owner (HM/O)-A. During the tour the surveyor observed the following: A hasp lock was present on the exterior of the unit door to resident room 4. This type of lock is not permitted and could lead to an obstruction of an egress path from the room. The hasp lock is not operable from the egress side of the door, and if secured would prevent an occupant from leaving the room. HM/O-A requested that the surveyor demonstrate the potential impact of the lock and upon demonstration stated they understood and would remove the lock. The egress window in resident room 5 would not open properly. The crank was not properly attached to the window assembly. The window should be brought to and maintained in proper	0 775			

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0 775	Continued From page 4 working order. Space heaters were in use in resident room 4 and resident room 5. These portable space heaters are not approved for use in resident rooms and may pose a fire risk. Space heaters should be removed. A multiplug adapter was in use for to power multiple electronics in resident room 5. This multiplug adapter was not rated as fire safe and should not be used as it may pose a fire hazard. HM/O-A acknowledged use of the unapproved multiplug adapters and stated that they would be removed from resident rooms. HM/O-A acknowledged the noted deficiencies during the tour and expressed that they would correct the deficiencies. TIME PERIOD FOR CORRECTION: Two (2) days	0 775			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;	0 780			

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0 780	Continued From page 5 (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms throughout the facility. This had the potential to directly affect all residents, staff, and visitors. 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: On October 15, 2025, from approximately 12:45 p.m. to 2:00 p.m., the surveyor toured the facility with house manager/owner (HM/O)-A. During the tour the surveyor observed the following:	0 780			

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0 780	Continued From page 6 During the tour HM/O-A tested smoke alarms by activating alarms in the lower-level common room, and resident room 5. When tested none of the smoke alarms were properly interconnected such that the activation of one alarm caused all other alarms in the facility to sound. HM/O-A stated the alarms were newly installed and that they may need actual smoke to alarm. HM/O-A lit a piece of paper on fire and allowed the smoke to set off the smoke alarm in the lower-level common area, but again no interconnection between alarms was observed. Smoke alarms must be interconnected such that all alarms sound upon the activation of any alarm in the facility. HM/O-A acknowledged the requirements and called an electrician to service the provided alarms. A smoke alarm was absent from a hardwired smoke alarm mount in the laundry room. The smoke alarm should be replaced in the laundry room and properly connected to hardwired power source and interconnected with smoke alarms provided in the facility. The smoke alarms provided in resident room 1 and in resident room 2 were still equipped with a plastic cover on the alarms that was provided for shipping but should be removed before use. The plastic cover may interfere with the alarms ability to detect smoke and therefore alert occupants. Covers should be removed, and the alarms should be maintained in proper working order without obstruction. During the facility tour interview on October 15, 2025, HM/O-A verified the above-listed fire protection and physical environment	0 780			

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0 780	Continued From page 7 observations while accompanying on the tour, and expressed that they would ensure interconnection and correct the deficiencies. TIME PERIOD FOR CORRECTION: Two (2) days	0 780			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system	0 810			

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0 810	Continued From page 8 activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content. This had the potential to directly affect all residents, staff, and visitors. 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 potential to affect a large portion or all of the residents). The findings include: On October 15, 2025, at approximately 1:15 p.m., house manager/owner (HM/O)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. The licensee FSEP failed to include the following: The FSEP failed to include appropriate employee actions to take during a fire or similar emergency. There was not any section provided in the FSEP outlining employee actions to take during an emergency. HM/O-A stated that such policies did exist but could not locate them during the survey	0 810			

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0 810	Continued From page 9 and no such documents were provided to the surveyor while at the facility. Later documents were emailed to the surveyor, but the documents included combined information for facility residents and staff. Employee actions for fire or another emergency should be readily available and accessible in the FSEP documents at the facility so they may be accessed by staff during an emergency. The FSEP failed to include documentation of unique resident needs for evacuation. HM/O-A stated that staff know the needs of residents for evacuation but that such needs are not documented in the FSEP. Unique resident needs should be documented to ensure staff can provide assistance and protection in event of emergency. During an interview on October 15, 2025, at approximately 2:30 p.m., the surveyor explained the requirements for staff procedures and FSEP documentation. HM/O-A stated they understood the requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
01640 SS=F	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	01640			

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01640	Continued From page 10 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 observation, interview, and record review, the licensee failed to ensure the service plan accurately reflected the current services provided for one of one resident (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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 13, 2025, at approximately 10:00 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated one resident (R1) wore compression garments but the	01640			

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01640	Continued From page 11 resident was currently in the hospital. R1 was admitted November 1, 2022, and had diagnoses including chronic obstructive pulmonary disease (COPD - damage to the lungs causing swelling and irritation) and lymphedema (swelling caused by accumulation of lymphatic fluid). R1's record included a provider order signed August 25, 2025, indicating R1 was prescribed velcro leg wraps for lymphedema. R1's service plan, dated September 11, 2023, indicated R1 received services including assistance with activities of daily living, and housekeeping. R1's service plan lacked indication staff assisted with lymphedema wraps. On September 14, 2025, at 1:25 p.m., CNS-B stated staff assisted R1 with applying compression garments every morning and removing them at night. CNS-B added they were not aware that the service plan needed to be updated with the current treatment of assistance with the lymphedema wraps. The licensee's Service Plan policy, undated, indicated the service plan would include, "A description of the services that are to be provided based on the most recent assessment and resident preferences." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38979	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/16/2025
NAME OF PROVIDER OR SUPPLIER MOUNDS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 7780 LONG LAKE ROAD MOUNDS VIEW, 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
01940	Continued From page 12	01940			
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and implement a treatment or therapy management	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38979	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/16/2025
NAME OF PROVIDER OR SUPPLIER MOUNDS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 7780 LONG LAKE ROAD MOUNDS VIEW, 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
01940	Continued From page 13 plan to include all required content for one of one resident (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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 13, 2025, at approximately 10:00 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated one resident (R1) wore compression garments but the resident was currently in the hospital. R1 was admitted November 1, 2022, and had diagnoses including chronic obstructive pulmonary disease (COPD - damage to the lungs causing swelling and irritation) and lymphedema (swelling caused by accumulation of lymphatic fluid). R1's record included a provider order signed August 25, 2025, indicating R1 was prescribed velcro leg wraps for lymphedema. The order lacked specific directions for application or wearing schedule. R1's service plan, dated September 1, 2023, indicated R1 received services including assistance with activities of daily living, and housekeeping. R1's service plan lacked indication R1 received assistance with	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38979	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/16/2025
NAME OF PROVIDER OR SUPPLIER MOUNDS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 7780 LONG LAKE ROAD MOUNDS VIEW, 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
01940	Continued From page 14 lymphedema wraps. R1's record lacked a treatment and therapy management plan for the lymphedema wraps, including: -documentation of specific resident instructions relating to the treatments or therapy administration. -identification of treatment or therapy tasks that will be delegated to unlicensed personnel; -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and -any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On October 14, 2025, at 1:30 p.m., CNS-B stated staff assisted R1 with applying compression garments every morning and removing them at night. CNS-B confirmed there was no treatment management plan developed for R1 and did not know a treatment plan was required. The licensee's Treatment and Therapy Management policy, dated October 13, 2025, indicated, "...that provides treatment and therapy management service "licensee" must develop, implement, and maintain up-to-date written treatment or therapy management and procedures. The policies and procedure's must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines."	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38979	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/16/2025
NAME OF PROVIDER OR SUPPLIER MOUNDS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 7780 LONG LAKE ROAD MOUNDS VIEW, 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
01940	Continued From page 15 No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01940			



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	License Info	Inspection Info
LIVE WELL MN HOME HEALTH CARE 7780 LONG LAKE ROAD Mounds View, MN 55112 Ramsey County Parcel: Phone:	License: HFID 38979 Risk: License: Expires on: CFPM: Betelham Walle CFPM #: 117928; Exp: 7/21/2026	Report Number: F1025251177 Inspection Type: Full - Single Date: 10/14/2025 Time: 3:00 PM Duration: minutes Announced Inspection: <u>Total Priority 1 Orders: 0</u> <u>Total Priority 2 Orders: 0</u> <u>Total Priority 3 Orders: 0</u> <u>Delivery:</u>

No orders were issued for this inspection report.

Food & Beverage General Comment

Discussed use and testing of dishwasher, chemical sanitizing and testing, food source, recalls, health and hygiene in the kitchen, food contact surfaces, utensil condition, date marking, use of available food thermometer, fact sheet postings, pest control.

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 F1025251177 from 10/14/2025

Beteleham

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	Inspection Info
LIVE WELL MN HOME HEALTH CARE	Report Number: F1025251177
Mounds View	Inspection Type: Full
County/Group: Ramsey County	Date: 10/14/2025
	Time: 3:00 PM

New Record: Product/Item/Unit: Milk; Temperature Process: Cold-Holding
Location: Refrigerator at 41 Degrees F.
Comment:
Violation Issued?: No