Electronically Delivered

February 26, 2026

Licensee
Keller Lake Commons
655 Norwood Lane
Big Lake, MN 55309

RE: Project Number(s) SL34175016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 23, 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 . . ."

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,

Kelly Thorson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34175	A. BUILDING: _____ B. WING _____	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KELLER LAKE COMMONS	655 NORWOOD LANE BIG LAKE, MN 55309

(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: SL34175016-0 On January 20, 2026, through January 22, 2026, 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 78 residents; 47 of whom were 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.	
0 450 SS=D	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall:	0 450		

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0 450	Continued From page 1 (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide services in a person-centered manner for one of one resident (R3). 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 January 20, 2026, at 9:45 a.m., clinical nurse supervisor (CNS)-D stated the licensee was familiar with current minimum assisted living requirements. R3 admitted to the licensee on May 8, 2024. R3's diagnoses included type 2 diabetes.	0 450		

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0 450	Continued From page 2 R3's service plan dated December 8, 2025, indicated services included medication administration. R3's prescriber orders dated May 15, 2025, included Lantus (insulin for diabetis management) 14 units subcutaneous every morning. R3's MD orders indicated, "Resident must demonstrate ability to self-administer, staff may verify dose." The licensee's Uniform Disclosure of Assisted Living Services and Amenities, dated October 21, 2025, indicated Diabetic Care: insulin pen dosing was available and the comments read, "Resident must be able to dial correct dose, staff will verify" On January 21, 2026, from 6:35 a.m., through 7:07 a.m., during continuous observation surveyor observed ULP-B provide morning cares to R3. ULP-B washed hands and helped R3 with his Lantus pen. ULP-B grabbed one alcohol wipe and handed it to R3, without scrubbing the tip of the pen ULP-B opened the needle and put the needle on the pen and handed it to R3. Without priming (dialing two units) the pen, R3 dosed the pen to 14 units. R3 then showed it to ULP-B to confirm the dose and then wiped an area on his abdomen with the alcohol wipe and injected the medication. Then R3 removed the needle and recapped it and set it on the table. ULP-B then placed the insulin pen back into locked storage. On January 21, 2026, at 7:07 a.m., ULP-B indicated that the resident is in chanrge of the insulin and she is only to check the dose and stated, "I always have them put the cap on so that it is safe to touch before I put it in the sharps. The residents are responsible for their own insulin, so	0 450		

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0 450	Continued From page 3 I was never really taught anything else. I only say something if it is not the right dose." R3's IMMP dated November 7, 2025, indicated R3 had a history of non-compliance and mismanagement of medications, R3 was unable to correctly read aloud or verbalize instructions on medication containers and R3 had low level literacy ability, and R3 was unable to verbalize what each medication was for and common side effects or correctly state when medications were taken or the proper dosage for each. It also indicated R3 had a complicated medication regimen and was unable to correctly measure the appropriate amount of medication from the container. R3 was unable to demonstrate secure storage for medication kept in room, and staff would assist with secure storage of medication. R3 was unable to correctly state situations for administering ordered 'as needed' medications or describe when to administer 'as needed' medications, and was unable to correctly administer topical ointments, creams or transdermal patches. The IMMP went on to read, "Staff are able to verify insulin dose, resident must self-inject. In summary, may self-administer medication safely -specify: No Based on assessment and not raking (sic) medications as ordered staff will administer medications." R3's IMMP contained information which was inconsistent and contraindicated R3's ability to safely manage or self-administer R3's medications, however based on the licensee's rules, R3 was unable to choose to have staff assist him in his insulin management. On January 22, 2026, at 11:27 a.m., registered nurse (RN)-A stated, "All our residents that are on insulin must self-administer it. They know that	0 450		

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0 450	Continued From page 4 when they move in." The Licensee's 6.31 Injections and Finger Punctures policy, dated August 1, 2021, indicated staff would perform insulin injections per direction and training from the nurse. The policy also indicated the proper steps for administering insulin from an insulin pen would include cleaning the port end of insulin pen with alcohol wipe and allowing it to dry, then remove seal on pen needle, screw pen needle to the end of the insulin pen, prime pen needle, by dialing pen to two units of insulin and pushing button to release the two units, then dialing up the correct dose to administer. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 450		
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 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	0 480		

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0 480	Continued From page 5 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 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:	0 480		

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0 480	Continued From page 6 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 January 20, 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		
0 510 SS=D	144G.41 Subd. 3 Infection control program (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.	0 510		

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0 510	Continued From page 7 (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 maintain an effective infection control program to comply with acceptable health care, medical, and nursing standards for infection control by one of three employees (unlicensed personnel (ULP)-B). 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: ULP-B ULP-B began working for the licensee on February 28, 2023, to provide direct care services to residents. On January 21, 2026, from 6:35 a.m., through 7:07 a.m., during continous observation surveyor observed ULP-B provide morning cares to R3. ULP-B washed hands and helped R3 with his Lantus (insulin for diabetes management) pen. ULP-B grabbed one alcohol wipe and handed it to R3, without scrubbing the tip of the pen, ULP-B opened the needle and put the needle on the pen and handed it to R3. Without priming (injecting two units) the pen, R3 dosed the pen to 14 units. R3 then showed it to ULP-B to confirm the dose	0 510		

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0 510	Continued From page 8 and then wiped an area on his abdomen with the alcohol wipe and injected the medication. Then R3 removed the needle and recapped it and set it on the table. Without putting on gloves, ULP-B grabbed the needle and placed it in the sharp's container. On January 21, 2026, at 7:07 a.m., ULP-B indicated that the resident is in chanrge of the insulin and she is only to check the dose and stated, "I always have them put the cap on so that it is safe to touch before I put it in the sharps. The residents are responsible for their own insulin, so I was never really taught anything else. I only say something if it is not the right dose." On January 22, 2026, at 11:27 a.m., registered nurse (RN)-A stated, "Our aides are not allowed to give the insulin, they are trained on verifying the dose and they are directed to update the nurses if they are doing it wrong, We allow the aides to put the pen together; they are trained to clean it and put the needle on and then give it to the resident and they remind the resident to prime it first. Then they are allowed to put the cover on and remove the needle and put it in sharps container. They should have gloves on through this entire process." RN-A indicated they had not had any updates on insulin being done wrong. The licensee's 6.31 Injections and Finger Punctures policy, dated August 1, 2021, indicated, insulin pens sheould be cleaned on the port end of insulin pen with alcohol wipe and allow to dry prior to dosing op the medication, and the end of pen needle should be cleaned with alcohol and the cover on pen replaced, and return to proper medication storage after administering the medication.	0 510		

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0 510	Continued From page 9 The licensee's 8.07 Gloves policy, dated August 1, 2021, indicated, gloves must be worn whenever there may be direct contact between any employee and contaminated objects or as instructed. 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 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 ensure screenings for active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented for one of three employees (unlicensed personnel (ULP)-E). This had the	0 660		

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0 660	Continued From page 10 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 potential to affect a large portion or all of the residents). The findings include: ULP-E began working for the licensee to provide direct cares to the residents on August 6, 2025. ULP-E's employee records included a Quantiferon TB gold test dated April 10, 2025, however it lacked evidence of screening for active TB with either a two-step TST or blood test within 90 days of hire. On January 22, 2026, at 11:38 a.m., registered nurse (RN)-A stated, "Usually, we do take results from about six months back if it is the gold test and three months back if it is the skin test, Its very rare to have someone with a blood test though, we usually just always do a skin test." The licensee's 8.16 Tuberculosis Screening policy, dated August 1, 2021, indicated all health care workers would receive a baseline TB screening upon hire using a two-step TST or single blood test to test for TB, and the results would be maintained in the employee's personnel record. No further information was provided.	0 660		

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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
0 660	Continued From page 11 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 by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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, Physical Environment Inspection Report (PEIR) dated 1-20-26, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) Days.	0 775		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34175	A. BUILDING: _____ B. WING _____	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KELLER LAKE COMMONS	655 NORWOOD LANE BIG LAKE, MN 55309

(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
0 780	Continued From page 12	0 780		
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; (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, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34175	A. BUILDING: _____ B. WING _____	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KELLER LAKE COMMONS	655 NORWOOD LANE BIG LAKE, MN 55309

(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
0 780	Continued From page 13 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, Physical Environment Inspection Report (PEIR) dated 1-20-26, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) Days.	0 780		
0 790 SS=C	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by:	0 790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34175	A. BUILDING: _____ B. WING _____	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KELLER LAKE COMMONS	655 NORWOOD LANE BIG LAKE, MN 55309

(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
0 790	Continued From page 14 Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 1-20-26, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) Days.	0 790		
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	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34175	A. BUILDING: _____ B. WING _____	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KELLER LAKE COMMONS	655 NORWOOD LANE BIG LAKE, MN 55309

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0 810	Continued From page 15 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 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 ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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).	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34175	A. BUILDING: _____ B. WING _____	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KELLER LAKE COMMONS	655 NORWOOD LANE BIG LAKE, MN 55309

(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
0 810	Continued From page 16 The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 1-20-26, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) Days.	0 810		
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for one employee (dietary aide (DA)-E). This had the potential to affect all	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34175	A. BUILDING: _____ B. WING _____	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KELLER LAKE COMMONS	655 NORWOOD LANE BIG LAKE, MN 55309

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01290	Continued From page 17 the residents residing in the assisted living facility. 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: DA-E began employment on April 17, 2025, to preform dining room duties. DA-E's employee records lacked evidence the licensee had a cleared background study for DA-E under the current assisted living license and affiliated to the licensee's HFID 34175. On January 21, 2026, at 7:18 a.m., licensed assisted living director (LALD)-C stated, "I emailed you yesterday after you left, we had a clearance letter for her, but we don't know why she fell off, so we reran it last night and again got a clearance letter, but I can show you that we had paid for her to have a background check and she did have one. She works as a dietary aide and there is always someone in the kitchen with her, but she is able to take orders from residents independently." The licensee's 4.02 Background Studies policy dated August 1, 2021, indicated the licensee would conduct a Minnesota Department of Human Services Background Study on all employees and volunteers and contractors that worked with the licensee,and no employee would	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34175	A. BUILDING: _____ B. WING _____	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KELLER LAKE COMMONS	655 NORWOOD LANE BIG LAKE, MN 55309

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01290	Continued From page 18 provide direct services and have independent direct contact with any residents until an acceptable result of the background study had been received. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded treatment orders were maintained for one of one resident (R8). 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).	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34175	A. BUILDING: _____ B. WING _____	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KELLER LAKE COMMONS	655 NORWOOD LANE BIG LAKE, MN 55309

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01970	Continued From page 19 The findings include: R5 was admitted to the licensee on August 5, 2025. R5 had diagnoses to include type 2 diabetes mellitus. R5's signed Addendum to Contract - Waiver - MN, dated December 24, 2025, indicated R5 received assistance with blood glucose monitoring, Dressing AM and PM, heavy housekeeping, laundry, medication management, bathing, dressing - special twice a day, and vitals. R5's Individualized Treatment and Therapy Plan, indicated clinical nurse supervisor (CNS)-D had put in the treatment plan on August 6, 2025, for R5 to receive, "Dressing - Special twice a day, HHA/RA - Assist client with TED stockings, on every morning and off every night. Hand wash and hang to dry at night." On January 21, 2026, at 7:44 a.m., surveyor observed unlicensed personnel (ULP)-H administer medication to R5. R5's signed provider orders dated August 5, 2025, lacked an order for compression stockings. On January 21, 2026, at 7:44 a.m., ULP-H stated, "We help her put her TEDS on each morning, but she has the right to refuse them and sometimes she just doesn't want to wear them." On January 22, 2026, at 11:31 a.m., registered nurse (RN)-A stated, "[R5] is newer to us, she has compression stockings that she brought with her and requested help with, so it was more of dressing assistance, but in order for us to do any	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34175	A. BUILDING: _____ B. WING _____	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KELLER LAKE COMMONS	655 NORWOOD LANE BIG LAKE, MN 55309

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01970	Continued From page 20 meds or treatments we need to contact the doctor and get an order. The licensee's 7.20 Medication and Treatment Orders policy dated August 1, 2021, indicated a written prescriber's order must be obtained for any treatment provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

KELLER LAKE COMMONS
655 Norwood Lane
Big Lake, MN 55309
Sherburne County
Parcel:

Phone:
nicole.gilder@vqpm.com

License Info

License: HFID 34175

Risk:
License:
Expires on:
CFPM: Linda Ellis-Smith
CFPM #: 33540; Exp: 12/15/2027

Inspection Info

Report Number: F7930261015
Inspection Type: Full - Single
Date: 1/20/2026 Time: 11:03:10 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 2
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery: Emailed

! 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: RAW HAMBURGER PATTIES AND RAW SHELL EGGS WERE STORED NEXT TO FAJITA VEGGIES AND SHREDDED CHEESE IN THE TOP OF THE MAIN PREP COOLER. SEPARATE LIKE STATED ABOVE TO PREVENT POSSIBLE CROSS-CONTAMINATION OF FOODS.

Comply By: Complied On Site Originally Issued On: 1/20/2026

! New Order: 3-500B Microbial Control: hot and cold holding

3-501.16A2 *Priority Level: Priority 1 CFP#: 22*

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

COMMENT: AT TIME OF INSPECTION SAUSAGE LINKS AND PASTA MEASURED 46 DEG F IN THE MAIN PREP COOLER (THEY WERE STORED ABOVE THE COLD RIM). STORE UNDER THE COLD RIM IN PREP COOLER TO MAINTAIN TEMPERATURES AT 41 DEG F OR BELOW. THESE ITEMS SHOULD NOT BE STORED ON TOP OF COLD HOLDING CONTAINERS IN THE TOP OF THE PREP COOLER.

Comply By: 1/20/2026 Originally Issued On: 1/20/2026

New Order: 4-900 Protecting Clean Items

4-903.11A *Priority Level: Priority 3 CFP#: 44*

MN Rule 4626.0955A Store all clean equipment, utensils, linens, single-service and single-use articles in a clean dry location where not exposed to splash, dust, or other contamination and at least six inches above the floor.

COMMENT: THERE WERE MULTIPLE BOXES OF SINGLE SERVICE ITEMS STORED ON THE FLOOR IN THE DRY STORAGE ROOM. STORE ALL BOXES UP OFF THE FLOOR AT LEAST 6 INCHES.

Comply By: 1/20/2026 Originally Issued On: 1/20/2026

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 St Cloud District Office inspection report number F7930261015 from 1/20/2026

Tina Remmele

Establishment Representative

Tina Remmele,
Public Health Sanitarian 3
320-223-7302
tina.remmele@state.mn.us

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Temperature Observations/Recordings

Establishment Info

KELLER LAKE COMMONS
Big Lake
County/Group: Sherburne County

Inspection Info

Report Number: F7930261015
Inspection Type: Full
Date: 1/20/2026
Time: 11:03:10 AM

New Record: Product/Item/Unit: SAUSAGE LINKS / PASTA**; Temperature Process:** Cold-Holding
Location: Prep Cooler (ABOVE COLD HOLDING RIM) at 46 Degrees F.
Comment:
Violation Issued?: Yes

New Record: Product/Item/Unit: DICED CUCUMBERS**; Temperature Process:** Cold-Holding
Location: Prep Cooler (TOP) at 40 Degrees F.
Comment:
Violation Issued?: No

New Record: Product/Item/Unit: DICED CHICKEN**; Temperature Process:** Cold-Holding
Location: Prep Cooler (BOTTOM) at 41 Degrees F.
Comment:
Violation Issued?: No

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

New Record: Product/Item/Unit: CHICKEN SOUP**; Temperature Process:** Hot-Holding
Location: Steam Table at 165 Degrees F.
Comment:
Violation Issued?: No

New Record: Product/Item/Unit: DICED TOMATOES**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 37 Degrees F.
Comment:
Violation Issued?: No

New Record: Product/Item/Unit: DICED CANTALOUPE**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Sanitizer Observations/Recordings

Establishment Info

KELLER LAKE COMMONS
Big Lake
County/Group: Sherburne County

Inspection Info

Report Number: F7930261015
Inspection Type: Full
Date: 1/20/2026
Time: 11:03:10 AM

New Record: **Product:** Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
Location: Prep Area (BOTTOM OF PREP TABLE) **Equal To**
Comment: 400PPM
Violation Issued?: No

New Record: **Product:** Chlorine**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To**
Comment: 50PPM (DISHWASHER FINAL RINSE CYCLE)
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL34175016-0	**Date:** 1/20/2026
Facility Name: KELLER LAKE COMMONS	
Facility Address: 655 Norwood Ln, Big Lake, Minnesota, 55309	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. Fire doors shall be maintained to be self-closing and latch as designed. Fire doors shall not be blocked, obstructed, or otherwise made inoperable. [Minn. Stat. 144G.45 subd. 2; MSFC 705]

   Comments: Fire doors in the following locations did not close and latch when tested: 1st floor elevator lobby doors, stairwell door outside of unit 136.

   A number of fire doors throughout the facility had permanently affixed door stops.

3. Exit signs shall be illuminated at all times. To ensure continued illumination for a duration of not less than 90 minutes in case of primary power loss, the sign illumination means shall be connected to an emergency power system provided from storage batteries, unit equipment or an on-site generator. [Minn. Stat. 144G.45 subd. 2; MSFC 1013.6.3]

   Comments: Exit lights in the following locations did not actuate when tested: outside unit 101, 136, 237, 231, 302, 308, 324, 212, 111, and the northeast stairway.

4. Compressed gas containers, cylinders and tanks shall be secured to prevent falling caused by contact, vibration or seismic activity. [Minn. Stat. 144G.45 subd. 2; MSFC 5303.5.3]

   Comments: Resident rooms with oxygen did not have the proper storage rack provided.

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Smoke alarms interconnected so that actuation of one alarm causes all alarms in the individual dwelling or sleeping unit to operate where more than one smoke alarm is required within an individual dwelling or sleeping unit. [Minn. Stat. 144G.45 subd.2]

   Comments: The smoke alarms in resident rooms 230, 336, 334 were not interconnected when a test was initiated.

2. Smoke alarms shall be tested and maintained in accordance with the manufacturer's instructions. Smoke alarms shall be replaced when they fail to respond to operability tests, or when they exceed 10 years from the date of manufacture, unless an earlier replacement is specified in the manufacturer's published instructions.

   Comments: The smoke alarms in units 301 and 212 had a manufactured date of April 19th, 2000.

☒ **TAG IDENTIFICATION: 0790**

SCOPE/ SEVERITY: Level 1; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Portable fire extinguishers installed and maintained to MN State Fire Code. [Minn. Stat. 144G.45 subd.2]

   Comments: The portable fire extinguishers throughout the facility lacked records to show monthly visual inspections were completed.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

   Comments: Licensed Assisted Living Director (LALD)-C was unable to produce a staff fire procedure policy when requested.

2. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

   Comments: LALD-C stated they train during evacuation drills but did not have documentation indicating the training was completed.