Electronically Delivered

March 26, 2026

Licensee
Trails of Orono Senior Living
875 Wayzata Boulevard
Orono, MN 55391

RE: Project Number(s) SL28637016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 5, 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 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 0775 - 144g.45 Subd. 2. (a) - 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

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28637	A. BUILDING: _____ B. WING _____	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRAILS OF ORONO SENIOR LIVING	875 WAYZATA BOULEVARD ORONO, MN 55391

(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: SL28637016-0 On March 2, 2026, through March 5, 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 47 residents; all of whom were receiving services under the Assisted Living Facility with Dementia Care 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.	
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

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0 510	Continued From page 1 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain an effective infection control program to comply with acceptable health care, medical, and nursing standards for infection control by two of three employees (unlicensed personnel (ULP)-B and ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-B began working for the licensee, providing direct cares to the residents on September 5, 2025. On March 3, 2026, from 7:55 a.m. through 8:10	0 510		

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0 510	Continued From page 2 a.m., surveyor observed ULP-B go into R5's room without performing hand hygiene and assisted R5 to the toilet. ULP-B put on clean gloves and applied lotion on R5's legs. ULP-B then removed gloves and without performing hand hygiene put on new gloves and provided peri care to R5, then removed soiled gloves and without performing hand hygiene put on a new glove on the right hand only. Then ULP-B assisted R5 with getting dressed and then removed the one glove. Without performing hand hygiene, ULP-B prepared R5's tooth brush with tooth paste and then assisted R5 with washing and drying her hands. ULP-B then transported R5 to the dining room and then performed hand hygiene. On March 3, 2026, at 8:11 a.m., ULP-B stated, "We are trained to wash our hands or use hand sanitizer when our hands are dirty or after we care for a resident. I usually do." ULP-E began working for the licensee, providing direct cares to the residents on December 18, 2025. On March 3, 2026, from 11:28 a.m. though 11:45 a.m., surveyor observed ULP-E go into R2's room without performing hand hygiene and dose up and administer medications and take vitals. Then ULP-E documented and exited R2's room without performing hand hygiene. ULP-E then went into R6's room without performing hand hygiene and put on gloves, then left R6's room to go to another room to grab incontinence products, ULP-E came back into R6's room wearing the same gloves and attempted to wake up R6. After making several attempts to assist R6 to participate in morning cares, ULP-E removed gloves and without performing hand hygiene left R6's room.	0 510		

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0 510	Continued From page 3 On March 3, 2026, from 12:02 p.m., through 12:12 p.m., surveyor observed ULP-E go into R2's room without performing hand hygiene and grab R2's blood glucose monitoring basket and insulin pen. ULP-E took the basket and insulin pen to the dining room where R2 was sitting at a dining room table with another resident. Without performing hand hygiene ULP-E put on gloves and obtained R2's blood glucose level. ULP-E then removed R2's belt while R2 was at the dining room table and lowered R2's pants to expose his lower abdomen, and administered insulin to R2's right lower quadrant. ULP-E the pulled R2's pants back up and fastened them and reapplied R2's belt. Then ULP-E removed his gloves and without performing hand hygiene he returned R2's insulin and blood glucose basket back in the medication cabinet in R2's room and documented. ULP-E then went to the kitchen and sat down with another resident and picked up the residents ice cream and spoon and went to assist with feeding the resident, when another ULP stated, "You need to wash your hands." ULP-E went into the kitchen and washed his hands. On March 3, 2026, at 12:22 p.m., regional registered nurse (RRN)-A stated, "Upon hire they go to sparks school, that is where we do our initial infection control and teach them handwashing and gloving and that they have to wash hands between gloving." The licensee's Hand Hygiene (Based upon the CDC Guideline Hand Hygiene in Healthcare Settings) policy, dated August 2025, indicated, "Hand washing shall be performed by all employees, as necessary, between tasks and procedures, and after bathroom use to prevent cross-contamination."	0 510		

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0 510	Continued From page 4 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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 March 3, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.	0 775		

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0 775	Continued From page 5 TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 790 SS=A	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: 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 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated	0 790		

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0 790	Continued From page 6 March 3, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
01540 SS=F	144G.64 (a) (3) Training in Dementia, Mental Illness, and De- (3) for assisted living facilities with dementia care, direct-care staff must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, the staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-E)	01540		

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01540	Continued From page 7 completed the required amount of dementia, mental illness, and de-escalation training in the required time frame. 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 is 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: ULP-E was hired and began providing assisted living services on December 18, 2025. ULP-E's employee file contained initial dementia to total a half hour, but lacked eight hours of training on dementia. On March 3, 2026, at 12:12 p.m., surveyor observed ULP-E in the dementia care unit assisting residents with lunch. On March 4, 2026, at 10:25 a.m., licensed assisted living director (LALD)-C stated, "For [ULP-E], I don't have it (dementia training), but I have pulled him off the floor and he is doing it now." Surveyor inquired if their were other staff that were missing the training, and LALD-C stated, "Yes, I don't know how many but I can run a report and let you know." On March 5, 2026, at 8:24 a.m., LALD-C sent an email that read, "Good Morning, I found 3 people that do not have the full 8 hours of dementia training completed and 5 people who do not have	01540		

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01540	Continued From page 8 the full 2 hours of mental health training. [LALD-C]" The licensee's Education policy, dated September 2024, indicated, all staff would have training covered that would ensure regulations were met. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
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 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.	01640		

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01640	Continued From page 9 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure there was a service plan initiated to document agreement on the services to be provided for one of one resident (R2, R3, and R7). 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 is 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: R2 R2 was admitted to the licensee and began receiving assisted living services on December 4, 2025. R2's record included a signed Assisted Living Contract dated December 16, 2025. On March 3, 2026, at 11:28 a.m., surveyor observed unlicensed personnel (ULP)-E provide medication administration to R2. R3 R3 was admitted to the licensee and began receiving assisted living services on February 4, 2026. R3's record included a signed Assisted Living Contract dated January 28, 2026.	01640		

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01640	Continued From page 10 R7 R7 was admitted to the licensee and began receiving assisted living services on January 8, 2026. R7's record included a signed Assisted Living Contract dated January 6, 2026. R2, R3, and R7's records lacked a service plan and agreement with the resident for services provided. On March 4, 2026, at 10:45 a.m., licensed assisted living director (LALD)-C stated, "We have been digging but have not found them, or they were not completed the way they should have been, that was under a different nurse and there is a reason she is not here anymore." The Licensee's Service Plan policy, dated September 2023, indicated, "All services provided to clients will be delivered after an assessment by an RN is completed, an up-to date Service Plan is signed by an RN and the client or the client's designated representative." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
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;	01650		

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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
01650	Continued From page 11 (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 interview and record review, the licensee failed to ensure the service plan included all required content for one of five residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28637	A. BUILDING: _____ B. WING _____	03/05/2026

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01650	Continued From page 12 The findings include: R4 was admitted and began receiving assisted living services on November 7, 2025. R4's Service Plan dated September 18, 2025, did not include services received. R4's Medication Administration Record (MAR) dated February 1, 2026, through February 28, 2026, and March 1, 2026, through March 31, 2026, indicated R4 received medication administration three times a day. R4's comprehensive nursing assessment dated November 21, 2025, indicated R4's services included medication administration by community licensed and unlicensed staff. R4's service plan lacked: - 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; - the identification of staff or categories of staff who will provide the services; - 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; - a contingency plan that includes: - 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. On March 4, 2026, at 10:45 a.m., licensed assisted living director (LALD)-C stated, "We	01650		

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01650	Continued From page 13 have been digging but have not found them, or they were not completed the way they should have been, that was under a different nurse and there is a reason she is not here anymore." The Licensee's Service Plan policy, dated September 2023, indicated, the resident's service plan would include all of the above-mentioned items. 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 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 medication was administered as prescribed for two of five residents (R2 and R4).	01760		

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01760	Continued From page 14 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2 R2 was admitted to the licensee and began receiving assisted living services on December 4, 2025. R2's record included a signed Assisted Living Contract dated December 16, 2025, however, lacked a service plan identifying agreed upon services between R2 and the licensee. On March 3, 2026, at 11:28 a.m., surveyor observed unlicensed personnel (ULP)-E provide medication administration to R2. R2's medication administration record (MAR) dated February 1, 2026, through February 28, 2026, indicated staff did not administer the following: - 11:00 a.m. medications which included Ferrous Sulfate 325 milligrams (mg) take one tablet by mouth Monday, Wednedsay, Friday for fatty liver/anemia, and Iferex 150 mg take one tablet by mouth for anemia/hypertention on February 11, 2026; - 9:00 p.m. medications which included acetaminophen 1000 mg take two tablets by mouth three times a day for pain, atorvastatin 20 mg take one tablet by mouth for fatty liver,	01760		

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01760	Continued From page 15 metoprolol tartrate 25 mg take one tablet by mouth for hypertention, preservision 1 capsule take one tablet by mouth twice daily for MD (macular degeneration), and senna plus 8.6-50 mg take one tablet by mouth twice daily for constipation on February 26, 2026. R2's MAR dated March 1, 2026, through March 31, 2026, indicated staff did not administer the following: - 9:00 p.m. medications which included acetaminophen 1000 mg take two tablets by mouth three times a day for pain, atorvastatin 20 mg take one tablet by mouth for fatty liver, metoprolol tartrate 25 mg take one tablet by mouth for hypertention, preservision 1 capsule take one tablet by mouth twice daily for MD (macular degeneration), and senna plus 8.6-50 mg take one tablet by mouth twice daily for constipation on March 1, 2026. R2's MAR indicated the medications were not given and no reason was documented. R4 R4 was admitted and began receiving assisted living services on November 7, 2025. R4's record included a signed Assisted Living Contract dated September 18, 2025, however, lacked a service plan identifying agreed upon services between R2 and the licensee. R4's MAR dated February 1, 2026, through February 28, 2026,, indicated staff did not administer the following: - 7:00 a.m. medications which included omeprazole 20 mg, one capsule daily by mouth for GERD (gastroesophageal reflux disease, a chronic upper gastrointestinal disease in which	01760		

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01760	Continued From page 16 stomach content persistently flows up into the esophagus) on February 6, 2026. R4's MAR indicated the medications were not given and no reason was documented. On March 3, 2026 at 12:28 p.m., regional registered nurse (RRN)-A stated, "The staff are trained that they document as soon as they are done administering medication, because if they don't document then it didn't happen." The Licensee's Medications & Treatments policy, dated December 2025, indicated the staff would document after assistance with medication reminder or medication administration, which would include the date, time, dosage, and method of administration of all medications, or the reason for not assisting with medication administration as ordered, and the initials of the nurse or authorized person who assisted or administered the medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01800 SS=D	144G.71 Subd. 11 Prescribed and nonprescribed medication The assisted living facility must determine whether the facility shall require a prescription for all medications the provider manages. The facility must inform the resident whether the facility requires a prescription for all over-the-counter and dietary supplements before the facility agrees to manage those medications.	01800		

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01800	Continued From page 17 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to determine whether the licensee shall require a prescription for all over-the counter (OTC) medications provided by the assisted living staff prior to managing the medication for one of seven residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on March 2, 2026, at 10:35 a.m., licensed assisted living director (LALD)-C and clinical nurse supervisor (CNS)-D stated the licensee provided medication management to residents at the facility. R4 was admitted and began receiving assisted living services on November 7, 2025. R4's Service Plan dated September 18, 2025, did not include services received. R4's Medication Administration Record (MAR) dated February 1, 2026, through February 28, 2026, and March 1, 2026, through March 31, 2026, indicated R4 received medication administration three times a day. R4's comprehensive nursing assessment dated	01800		

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01800	Continued From page 18 November 21, 2025, indicated R4's services included medication administration by community licensed and unlicensed staff. On March 4, 2026, at 8:03 a.m., surveyor observed unlicensed personnel (ULP)-H enter R4's room to administer medications. Located in R4's kitchen was a medication set-up container with unknown medications set up in the boxes for seven days, as well as a bottle of TUMS, a bottle of airborne, a bottle of zzzquil, a bottle of iron supplements, a bottle of Aleve PM, and a bottle of Pepcid. All over-the-counter bottles of medication contained an unknown amount of medication. On March 4, 2026, at 8:06 a.m., ULP-H stated, "I asked about those, she used to do her own meds, and when I asked about those being out, I was told it was ok so I leave them alone." On March 4, 2026, at 10:40 a.m., clinical nurse supervisor (CNS)-D stated, "Well this is the first I am hearing about it so I am sure we don't have orders, but I will have to look into it, maybe her family brought them, and we were not made known of it." The Licensee's Medications & Treatments policy, dated December 2025, indicated, the nurse would be responsible for assuring the licensee had authorized prescriber orders for medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01800		
01880 SS=F	144G.71 Subd. 19 Storage of medications	01880		

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01880	Continued From page 19 An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescription medications were securely locked in a substantially constructed compartment and permitted only authorized personnel to have access for one of five residents (R2 and R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is 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: R2 R2 was admitted to the licensee and began receiving assisted living services on December 4, 2025. R2's record included a signed Assisted Living Contract dated December 16, 2025. R2's medication administration record (MAR) dated March 1, 2026, through March 31, 2026, indicated R2 received medication administration three times a day.	01880		

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01880	Continued From page 20 On March 3, 2026, from 12:02 p.m., through 12:12 p.m., surveyor observed ULP-E go into R2's room and grab R2's blood glucose monitoring basket and insulin pen. ULP-E took the basket and insulin pen to the dining room leaving R2's medication cabinet unlocked and R2's bedroom door wide open. ULP-E then placed the basket and all the contents onto the table that R2 was at with another resident and walked away to another part of the facility. There were 15 residents in the dining room at the time. ULP-E returned to the medication and after administering the insulin to R2, ULP-E returned R2's insulin and blood glucose basket back in the medication cabinet in R2's room and locked the medication cabinet. On March 3, 2026, at 12:10 p.m., ULP-E stated, ""meds should be locked every time we leave them. When we leave the room we are supposed to lock the cabinet and then unlock it only when we need to get things out, we do everything in here but today he moved fast and was already out there so I had to grab and go." On March 3, 2026, at 12:22 p.m., regional registered nurse (RRN)-A stated, "We talk about in sparks school, and they are all trained that they (medications) need to be locked and stored unless they have an order to leave at bedside." R4 R4 was admitted and began receiving assisted living services on November 7, 2025. R4's Service Plan dated September 18, 2025, did not include services received. R4's Medication Administration Record (MAR) dated February 1, 2026, through February 28,	01880		

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01880	Continued From page 21 2026, and March 1, 2026, through March 31, 2026, indicated R4 received medication administration three times a day. On March 4, 2026, at 8:03 a.m., surveyor observed unlicensed personnel (ULP)-H enter R4's room to administer medications. Located in R4's kitchen was a medication set-up container with unknown medications set up in the boxes for seven days, as well as a bottle of TUMS, a bottle of airborne, a bottle of zzzquil, a bottle of iron supplements, a bottle of Aleve PM, and a bottle of Pepcid. All over-the-counter bottles of medication contained an unknown amount of medication. On March 4, 2026, at 8:06 a.m., ULP-H stated, "I asked about those, she used to do her own meds, and when I asked about those being out, I was told it was ok so I leave them alone." On March 4, 2026, at 10:40 a.m., clinical nurse supervisor (CNS)-D stated, "Well this is the first I am hearing about it so I am sure we don't have orders, but I will have to look into it, maybe her family brought them, and we were not made known of it." The Licensee's Medications & Treatments policy, dated December 2025, indicated, "Medications managed inside a resident's private "living space" must be securely locked and substantially constructed compartments and permit only authorized personnel to have access. They may be a locked drawer, cabinet, etc. The keys will be stored in a secured cabinet when not in use by authorized personal." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7)	01880		

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01880	Continued From page 22 days	01880		
02160 SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (a) In addition to the minimum services required in section 144G.41, an assisted living facility with dementia care must also provide the following services: (1) assistance with activities of daily living that address the needs of each resident with dementia due to cognitive or physical limitations. These services must meet or be in addition to the requirements in the licensing rules for the facility. Services must be provided in a person-centered manner that promotes resident choice, dignity, and sustains the resident's abilities; (2) nonpharmacological practices that are person-centered and evidence-informed; (3) services to prepare and educate persons living with dementia and their legal and designated representatives about transitions in care and ensuring complete, timely communication between, across, and within settings; and (4) services that provide residents with choices for meaningful engagement with other facility residents and the broader community. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure dementia care services provided to residents promoted dignity for one of five residents (R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	02160		

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02160	Continued From page 23 safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2 was admitted to the licensee and began receiving assisted living services on December 4, 2025. R2's record included a signed Assisted Living Contract dated December 16, 2025. On March 3, 2026, from 12:02 p.m. through 12:12 p.m., surveyor observed unlicensed personnel (ULP)-E go into R2's room and grab R2's blood glucose monitoring basket and insulin pen and take it to the dining room where R2 was sitting at a dining room table with another resident. Without offering or providing privacy ULP-E put on gloves and obtained R2's blood glucose level. Without offering or providing privacy, ULP-E then removed R2's belt while R2 was at the dining room table and lowered R2's pants to expose his lower abdomen, and administered insulin to R2's right lower quadrant. ULP-E then pulled R2's pants back up and fastened them and reapplied R2's belt. ULP-E then returned R2's insulin and blood glucose basket back in the medication cabinet in R2's room and documented. On March 3, 2026, at 12:10 p.m., ULP-E stated, "We do everything in here but today he moved fast and was already out there, so I had to grab and go." On March 3, 2026, at 12:22 p.m., regional	02160		

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02160	Continued From page 24 registered nurse (RRN)-A stated, "Blood sugar and insulin, again the teaching is done in sparks school and we teach them they have to do it in private for dignity and infection control and wear gloves because you never know if there will be blood." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02160		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure a required notice was posted at the main entry way of the facility to display statutory language to disclose electronic monitoring activity. This had the potential to affect all six residents, staff, and visitors to the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a 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	03090		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRAILS OF ORONO SENIOR LIVING	875 WAYZATA BOULEVARD ORONO, MN 55391

(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
03090	Continued From page 25 the residents). The findings include: On March 2, 2026, at 11:30 a.m., the surveyor observed no electronic monitoring notice posted in the facility with the statutory required language. On March 2, 2026, at 11:59 a.m., via email, licensed assisted living director (LALD)-C indicated, "We do not have this, but I have ordered stickers for all of the doors." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

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

Establishment Info

TRAILS OF ORONO ASSISTED LIVIN
875 WAYZATA BOULEVARD
Orono, MN 55391
Hennepin County
Parcel:

Phone:

License Info

License: HFID 28637

Risk:
License:
Expires on:
CFPM: Parker Detewiler
CFPM #: 65076; Exp: 2/18/2029

Inspection Info

Report Number: F8041261039
Inspection Type: Full - Single
Date: 3/2/2026 Time: 1:00 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

Inspection was completed with Parker Detweiler (Director of Culinary). Tesa Brown was the lead Health Regulation Division Nurse Evaluator.

This facility has a commercial kitchen on the main floor and a kitchenette in memory care (Pineview).

Discussed the following:
- Employee illness policy and logging requirements
- Reporting foodborne illness complaints to the health dept.
- Handwashing
- Date marking
- Glove-use and bare hand contact
- Proper food storage
-Vomit clean-up procedures
- Restrictions concerning serving a highly susceptible population

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 F8041261039 from 3/2/2026

Parker Detweiler
Director of Culinary

Sarah Conboy,
Public Health Sanitarian Supervisor
651-201-3984
sarah.conboy@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

TRAILS OF ORONO ASSISTED LIVIN
Orono
County/Group: Hennepin County

Inspection Info

Report Number: F8041261039
Inspection Type: Full
Date: 3/2/2026
Time: 1:00 PM

Food Temperature: Product/Item/Unit: cut melon**; Temperature Process:** Cold-Holding
Location: reach-in cooler/memory care at 36 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: sliced tomatoes**; Temperature Process:** Cold-Holding
Location: prep cooler at 36 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: whipping cream**; Temperature Process:** Cold-Holding
Location: 2 door cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: pork with gravy**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 36 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: chili**; Temperature Process:** Cold-Holding
Location: walk-in cooler at 36 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: tomato parm. **; Temperature Process:** Hot-Holding
Location: Soup Well at 143 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: milk**; Temperature Process:** Cold-Holding
Location: reach-in cooler/serving area at 37 Degrees F.
Comment:
Violation Issued?: No

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Sanitizer Observations/Recordings

Establishment Info

TRAILS OF ORONO ASSISTED LIVIN
Orono
County/Group: Hennepin County

Inspection Info

Report Number: F8041261039
Inspection Type: Full
Date: 3/2/2026
Time: 1:00 PM

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
Location: Kitchen Cook Line **Equal To** 200 PPM
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
Location: Memory care **Equal To** 200 PPM
Comment:
Violation Issued?: No

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Greater Than** 160 Degrees F.
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL28637016	**Date:** 3/3/2026
Facility Name: Trails of Orono Senior Living	
Facility Address: 875 Wayzata Blvd, Wayzata, Minnesota 55391	

☒ **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. The emergency power system for means of egress illumination shall provide power for not less than 30 minutes and consist of storage batteries, unit equipment, or an on-site generator. [Minn. Stat. 144G.45 subd. 2; MSFC 1104.5.3]

   Comments: The emergency lighting at the hallway intersection of the memory care unit, and in the hallway near room 212 did not illuminate when tested. Provided emergency lighting must have backup power maintained in functional condition to provide lighting during a power outage. The batteries did not function to power the emergency lights and the facility did not have a generator installed at time of inspection.

3. Controlled egress locking systems shall: unlock upon activation of either the automatic sprinkler system or automatic fire detection system, unlock upon loss of power controlling the lock, have the capability of being unlocked from the fire command center, a nursing station, or other approved location. Building occupants shall not be required to pass through more than one controlled egress locked door before entering an exit. The procedures for operation of the unlocking system shall be described as part of the fire safety and evacuation plan. All clinical staff shall have the keys, codes, or other means necessary to operate the locking device. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9.7]

   Comments: No remote release button or switch was provided to break power to all controlled egress doors. The memory care wing of the facility had controlled egress doors limiting the ability to exit from that area. There was no method to release all controlled egress doors via remote release button or switch to unlock the controlled egress doors in the memory care wing. Pull stations were available at each door that corresponded to the corresponding door, but were not capable of unlocking any other

doors in the facility. Controlled egress doors should have the capability of being unlocked from an approved location.

4. Clothes dryers and their exhaust systems shall be cleaned as necessary to keep lint traps, exhaust ducts, and mechanical and heating components free from excessive lint accumulation. [Minn. Stat. 144G.45 subd. 2; MSFC 304.4]

   Comments: The dryer vent in the laundry room of the memory care wing was not properly connected and a significant amount of lint had accumulated behind the clothing dryer. Accumulated lint may pose a fire hazard and should be removed and dryer ventilation plumbing should be maintained in proper working order and condition.

5. Extension cords and flexible cords shall not be a substitute for permanent wiring and shall be listed and labeled in accordance with UL 817. Extension cords and flexible cords shall not be affixed to structures, extended through walls, ceilings or floors, or under doors or floor coverings, nor shall such cords be subject to environmental damage or physical impact. Extension cords shall be used only with portable appliances. Extension cords marked for indoor use shall not be used outdoors. [Minn. Stat. 144G.45 subd. 2; MSFC 604.5]

   Comments: An extension cord was in use to power multiple electronics in the living room of resident room 213. Extension cords should not be used in lieu of permanent wiring and may pose a fire hazard.

☒ **TAG IDENTIFICATION: 0790**

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

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

   Comments: The fire extinguisher provided in the salon on the second floor of the facility had an expired annual service tag indicating it was last serviced in August 2023. All fire extinguishers should have annual servicing by licensed contractor and should receive monthly visual inspections by facility staff. The extinguisher provided in the salon should be serviced and have monthly staff inspections to ensure condition and operability.