Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL390812006M
Compliance #: HL390813635C

Date Concluded: July 8, 2025

Name, Address, and County of Licensee Investigated:
Round Lake Senior Living
1740 Parkshore Drive
Arden Hills, MN 55112
Ramsey County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Brooke Anderson, RN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The facility neglected the resident when the resident fell and wasn't checked on for approximately three hours. The resident was sent to the hospital for evaluation and later passed from his injuries.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility had no system in place for residents to call or summon for emergency assistance. Facility management indicated there was no call light or pendant system, but that staff instead completed hourly safety checks on the residents and the facility had a motion alert system to detect falls. During interview with the nurse employed at the time of the incident, the nurse acknowledged the facility was aware of concerns with the functionality of the motion alert system prior to the resident's fall but indicated no additional interventions were implemented to address the issues. Additionally, staff did not complete the hourly checks at the time the incident occurred.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, death record, hospital records, facility internal investigation documentation, incident reports, personnel files, staff schedules, and related facility policies and procedures. Also, the investigator observed interactions between staff and residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia and major depressive disorder. The resident's service plan included assistance with escorts to and from meals, laundry, and medication administration. The resident's assessment indicated the resident had severe cognitive impairment and walked independently with a walker. The resident had a history of falls and was at risk for falls related to impaired balance.

An incident report indicated when checking on the resident at 7:40 a.m. the resident was found on the floor by the bed, and he was bleeding "profusely" from his head and shoulder. 911 was called and the resident was sent to the emergency room for evaluation

Facility internal investigation documentation indicated the resident was last checked on approximately five hours prior to the fall. The electric monitoring system did not detect the incident; the system indicated a "missed fall" but did not alert staff. The facility was able to obtain video footage after the incident.

Video footage indicated the resident sat up at 5:18 a.m. on the side of bed and fell forward to the ground without bracing himself. The video footage was only of the incident, not what happened before or after the incident.

Hospital records indicated the resident had an unwitnessed fall and was found on the ground in the morning. The resident was last seen on nighttime rounds and was on the ground for an unknown period of time. The resident had semi-clotted blood on the floor next to him when he was found. The resident was diagnosed with acute subarachnoid hemorrhage (bleeding in the brain) and rhabdomyolysis (the breakdown of muscle tissue, frequently caused by prolonged immobilization, often following a fall). The resident had seizure activity related to the injuries, was placed on hospice and passed away approximately two weeks after the fall.

The death record indicated the resident died from complications of blunt force intracranial hemorrhages due to a fall.

During an interview, staff member #1 stated he worked the night shift before the incident and he completed safety checks. Staff member #1 provided conflicting accounts of how often the safety checks were to be completed and was unsure if he or his coworker did the checks.

During an interview, staff member #2 stated she started in the morning, got report from the night shift and then went to complete rounds. When she entered the room, she found the

resident on the ground between his bed and the wall with his back leaned up against the nightstand. The resident was wiping his face trying to get the blood out of his eyes. Staff member #2 stated when she walked in the room and saw the resident, she was so scared and ran out to get help. Staff member #2 stated “there was so much blood, it was a terrible scene.” 911 was called and the resident was sent to the emergency room. Staff member #2 stated in the memory care unit, safety checks were to be completed every hour.

During an interview, the former facility nurse employed at the time of the incident stated the memory care unit used an electronic monitoring system instead of emergency pendants because residents with dementia could not use the pendants appropriately. Staff were educated to respond to the electronic monitoring system alert promptly; however, the system was not working correctly the morning of the incident and staff were not alerted the resident was on the ground. Facility management stated the electronic monitoring system was not capturing events. Around the time of the incident, the facility management was having weekly meetings with the monitoring company to discuss issues. The nurse stated that facility staff were supposed to complete every hour checks on residents; however, after this incident it was identified the safety checks were not being completed. Facility management stated there was not a specific person responsible for ensuring the system was working correctly.

No policy, procedure, training, or education for the electric monitoring system was provided for the investigation.

During an interview, a family member stated when the resident moved into the facility, he was told about the electronic monitoring system and that was why he did not add additional services for the resident. When the resident got to the hospital, staff were concerned about the blood loss the resident had experienced. The resident passed from his injuries and although the fall may not have been prevented, the extended length of time he was on the floor could have made a difference in the outcome.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
“Neglect” means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
When the resident was found on the ground 911 was called immediately.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Ramsey County Attorney
Arden Hills City Attorney
Arden Hills Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39081	A. BUILDING: _____ B. WING _____	C 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROUND LAKE SENIOR LIVING	1740 PARKSHORE DRIVE ARDEN HILLS, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL390813635C/#HL390812006M On June 4, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 79 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for ##HL390813635C/#HL390812006M, tag identification 2360.	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.	

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02360	Continued From page 1	02360		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		