DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL390814021M
Compliance #: HL390814604C

Date Concluded: October 31, 2024
Date of Reconsideration Determination: July 30, 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: James P. Larson, RN
Special Investigator
Reconsideration Analyst: Jacci Nickell

Finding: Substantiated, facility responsibility**,** ~~Individual responsibility~~ changed to Inconclusive.

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 ~~and the alleged perpetrator (AP), a facility nurse~~, neglected the resident when they failed to follow proper facility process and procedure and did not contact emergency medical services (EMS) after the resident was found unresponsive.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility ~~and the AP~~ was responsible for the maltreatment. Facility policies and procedures were not followed by licensed and unlicensed staff. Upon discovering the resident unresponsive, facility staff failed to immediately notify emergency medical services for assistance and failed to initiate cardiopulmonary resuscitation (CPR) on the resident who was a full code status.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigation included review of the resident record, death record, facility internal investigation documentation, personnel files, staff schedules, and facility policies and procedures. The investigator also spoke with a law enforcement officer. The investigator toured the facility, observed staff interacting with residents and completing scheduled care activities at the time of the onsite visit.

The resident resided in an assisted living facility. The resident's diagnoses included heart failure, heart disease, and renal failure. The resident's service plan included assistance with activities of daily living, housekeeping, meal reminders, transfer assistance, prosthetic care, and safety checks. The resident's assessment indicated that the resident's code status (type of emergent treatment a person would or would not receive if their heart or breathing were to stop) was indicated as full code (all resuscitative and aggressive curative treatments are provided). The resident's assessment indicated the resident was cognitively intact and able to communicate his needs.

During a scheduled nighttime check around 12:50 a.m., unlicensed person (ULP) found the resident unresponsive in his bed. ULP called the on-call registered nurse (RN) and the executive director for guidance, and the nurse instructed ULP to not contact emergency medical services (EMS). The ULPs and the RN did not review the resident's code status at the time the resident was found unresponsive. Instead, the resident's family was contacted and informed that the resident was found deceased. The family arrived at the facility approximately three hours later and when they asked staff about the process for after life care, they were told they needed to contact a funeral home to make arrangements.

The family contacted the funeral home who directed them to contact EMS to report the resident's death. EMS arrived at the facility a short time later and pronounced the resident deceased.

During an interview, the facility administrator stated that all employees received training on proper procedures and protocols involved in response to a resident death and could access the policy and procedure database for reference at any time. The administrator confirmed staff did not follow procedures, as the resident was a full code status and emergency services should have been contacted after the resident was found unresponsive.

During an interview, the alleged perpetrator (AP), a registered nurse (RN), who was on call the night of the incident, could not recall specifics of the incident. The AP/RN did not recall being given specific information relating to the resident's condition, vital signs, or events leading up to the discovery of the resident. The AP/RN verified she failed to follow facility protocol relating to an unexpected death at the facility when she instructed ULP to not immediately call 911.

During an interview, the ULP who first found the resident stated she entered the room approximately four hours after the resident's last service was recorded. She immediately called

the nurse for direction and was told to not notify 911. Later, a second ULP called the nurse for clarification and was told not to notify 911 but to contact the family.

During an interview, the second ULP who assisted when the resident was found unresponsive, stated she initially called the facility administrator for direction on how to proceed and was told to call 911. However, upon hearing the information given to the first ULP by the on-call nurse, she contacted the nurse for clarification and was informed to notify the family and not to call 911.

During an interview with a family member, they stated they were informed by staff that the resident was found deceased. After the family arrived at the facility, staff told them to contact the funeral home to report the resident's death. The funeral home told the family to call 911. Facility staff told the family they could not make the call to 911, so the family had to contact 911 to report the resident's death.

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: Yes

Action taken by facility:
The facility conducted an internal investigation. Facility staff members received additional training on emergency process and procedures.

Action taken by the Minnesota Department of Health:

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

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

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
Ramsey County Sherriff Department
Arden Hills Police Department
Minnesota Board of Nursing
Medical Examiner

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 08/30/2024

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

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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: #HL390814604C/#HL390814021M On August 30, 2024, 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 104 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL390814604C/#HL390814021M, tag identification 0130, 2320, and 2360.	0 000	Assisted Living Provider 144G. 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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0 130	Continued From page 1	0 130		
0 130 SS=C	144G.12, Subd. 1 Application for Licensure Each application for an assisted living facility license, including provisional and renewal applications, must include information sufficient to show that the applicant meets the requirements of licensure, including: (1) the business name and legal entity name of the licensee, and the street address and mailing address of the facility; (2) the names, e-mail addresses, telephone numbers, and mailing addresses of all owners, controlling individuals, managerial officials, and the assisted living director; (3) the name and e-mail address of the managing agent and manager, if applicable; (4) the licensed resident capacity and the license category; (5) the license fee in the amount specified in section 144.122; (6) documentation of compliance with the background study requirements in section 144G.13 for the owner, controlling individuals, and managerial officials. Each application for a new license must include documentation for the applicant and for each individual with five percent or more direct or indirect ownership in the applicant; (7) evidence of workers' compensation coverage as required by sections 176.181 and 176.182; (8) documentation that the facility has liability coverage; (9) a copy of the executed lease agreement between the landlord and the licensee, if applicable; (10) a copy of the management agreement, if applicable; (11) a copy of the operations transfer agreement or similar agreement, if applicable;	0 130		

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0 130	Continued From page 2 (12) an organizational chart that identifies all organizations and individuals with an ownership interest in the licensee of five percent or greater and that specifies their relationship with the licensee and with each other; (13) whether the applicant, owner, controlling individual, managerial official, or assisted living director of the facility has ever been convicted of: (i) a crime or found civilly liable for a federal or state felony level offense that was detrimental to the best interests of the facility and its resident within the last ten years preceding submission of the license application. Offenses include: felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; any felonies involving malpractice that resulted in a conviction of criminal neglect or misconduct; and any felonies that would result in a mandatory exclusion under section 1128(a) of the Social Security Act; (ii) any misdemeanor conviction, under federal or state law, related to: the delivery of an item or service under Medicaid or a state health care program, or the abuse or neglect of a patient in connection with the delivery of a health care item or service; (iii) any misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service; (iv) any felony or misdemeanor conviction, under federal or state law, relating to the interference	0 130		

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0 130	Continued From page 3 with or obstruction of any investigation into any criminal offense described in Code of Federal Regulations, title 42, section 1001.101 or 1001.201; (v) any felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; (vi) any felony or gross misdemeanor that relates to the operation of a nursing home or assisted living facility or directly affects resident safety or care during that period; (vii) any revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority; (viii) any revocation or suspension of accreditation; or (ix) any suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or nonprocurement program; (14) whether, in the preceding three years, the applicant or any owner, controlling individual, managerial official, or assisted living director of the facility has a record of defaulting in the payment of money collected for others, including the discharge of debts through bankruptcy proceedings; (15) the signature of the owner of the licensee, or an authorized agent of the licensee; (16) identification of all states where the applicant or individual having a five percent or more ownership, currently or previously has been licensed as an owner or operator of a long-term care, community-based, or health care facility or	0 130		

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0 130	Continued From page 4 agency where its license or federal certification has been denied, suspended, restricted, conditioned, refused, not renewed, or revoked under a private or state-controlled receivership, or where these same actions are pending under the laws of any state or federal authority; (17) statistical information required by the commissioner; and (18) any other information required by the commissioner. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to hold an assisted living with dementia care license for their current capacity of residents. The assisted living with dementia care license effective January 1, 2024, indicated a capacity of 70 residents, however 104 residents resided at 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 the potential to affect a large portion or all the residents). The findings include: On August 30, 2024 licensed assisted living director (LALD)-A provided a resident roster dated August 30, 2024 which indicated a total resident census of 104 of which 36 residents were not receiving any nursing services but resided within the licensed building. The licensee's application for an assisted living	0 130		

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0 130	Continued From page 5 license, signed by administrator (AD)-B on January 5, 2024 indicated the capacity was 70 residents. During an interview on September 6, 2024 at 4:00 p.m. AD-B stated that at the time of the current assisted living license renewal request in January 2024 she was the LALD on record for the facility but could not recall the building resident census at that time. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 130		
02320 SS=G	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure services were provided by people who were properly trained and competent to perform their duties for one of one resident (R1) who was a full-code status when emergency medical services (EMS) were not contacted after R1 was found unresponsive. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	02320		

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not including serious injury, impairment, or death, or a violation that has the potential to lead to 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:

R1's medical record indicated R1 admitted to the facility on September 22, 2023.

R1's service plan dated January 18, 2024, indicated the resident required assistance with activities of daily living, housekeeping, meal reminders, transfer assistance, prosthetic care, and safety checks.

R1's assessment dated June 5, 2024 indicted there were no advance directives on file and that R1's code status was full code.

A facility report dated June 5, 2024, indicated that during a scheduled nighttime check on June 5, 2024 at approximately 12:28 a.m. unlicensed person (ULP)-E entered R1's apartment and discovered R1 unresponsive in bed. ULP-E then contacted ULP-F and requested assistance. Attempts by ULP-E to obtain vital signs or signs of life failed and calls were made to the facility on-call registered nurse (RN)-C and to the executive director (ED)-B. RN-C instructed the ULP-E not to contact emergency medical services (EMS). ULP-F called RN-C to verify the instructions and again RN-C instructed to not call EMS. RN-C did not contact EMS but chose to contact a family member to inform them of the event. A family member arrived at the facility hours later at approximately 1:54 a.m. when they

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02320	Continued From page 7	02320		

inquired the staff of what the process was in place to provide after life care they were directed to call a funeral home of their choosing to make arrangements. Under direction of a local funeral home, the family then called 911 to report the residents passing approximately three hours after the resident was found unresponsive at approximately 3:00 a.m. Law enforcement and EMS personnel arrived on scene at 3:06 a.m. and the resident was pronounced deceased at that time.

During an interview on September 6, 2024 at 3:00 p.m. ULP-F stated that during her initial call to ED-B she was directed to call 911 and then call the on-call nurse. ULP-F went on to recall that she called the RN on call to verify the instruction and did not call 911.

During an interview on September 9, 2024 at 10:00 a.m. RN-C stated that there were policy and procedures available as well as facility documents for reference that were not followed indicating that 911 should be notified immediately. RN-C verified she instructed the facility staff not to call 911 with the information received despite R1 being a full-code status.

ULP-E's employee record was reviewed and indicated ULP-F received General Orientation: HR Overview (LSL ALF) training and Natural Disasters and Workplace Emergencies: An Overview on April 14, 2024.

ULP-F's employee record was reviewed and indicated ULP-F received General Orientation: HR Overview (LSL ALF) training on January 1, 2024 and Natural Disasters and Workplace Emergencies: An Overview on April 4, 2024.

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02320	Continued From page 8 RN-C's employee record was reviewed and indicated RN-C received Triage Senior Living Guidelines training on September 28, 2023 and LifeSpark Policies and Procedures training on November 14, 2023. 2023 Minnesota Statutes Sections 148.171 to 148.285 shall be referred to as the Minnesota Nurse Practice Act. Subd. 15.Practice of professional nursing. The "practice of professional nursing" means the performance, with or without compensation, of those services that incorporates caring for all patients in all settings through nursing standards recognized by the board and includes, but is not limited to: (1) providing a comprehensive assessment of the health status of a patient through the collection, analysis, and synthesis of data used to establish a health status baseline and plan of care, and address changes in a patient's condition; (2) collaborating with the health care team to develop and coordinate an integrated plan of care; (3) developing nursing interventions to be integrated with the plan of care; (4) implementing nursing care through the execution of independent nursing interventions; (5) implementing interventions that are delegated, ordered, or prescribed by a licensed health care provider; (6) delegating nursing tasks or assigning nursing activities to implement the plan of care; (7) providing safe and effective nursing care; (8) promoting a safe and therapeutic environment; (9) advocating for the best interests of individual patients; (10) evaluating responses to interventions and the effectiveness of the plan of care; (11) collaborating and coordinating with other	02320		

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02320	Continued From page 9 health care professionals in the management and implementation of care within and across care settings and communities; (12) providing health promotion, disease prevention, care coordination, and case finding; (13) designing and implementing teaching plans based on patient need, and evaluating their effectiveness; (14) participating in the development of health care policies, procedures, and systems; (15) managing, supervising, and evaluating the practice of nursing; (16) teaching the theory and practice of nursing; and (17) accountability for the quality of care delivered, recognizing the limits of knowledge and experience; addressing situations beyond the nurse's competency; and performing to the level of education, knowledge, and skill ordinarily expected of an individual who has completed an approved professional nursing education program as described in section 148.211, subdivision 1. The licensee's RN After Hours - Senior Living policy dated March 2024, indicated ensure effective triage processes are incorporated, expectations and responsibilities for on-call, after hours RN and community staff are defined and outlined. The RN on-call nurse, a Lifespark or community-employed RN, functions in a capacity through Lifespark/Lifespark Senior Living and is dedicated to serving as on-call for Lifespark Assisted Living communities. In the Event of a significant change in condition, resident fall, other emergent situation, the On-Call RN will: Determine severity and client's wishes (i.e. Do Not Hospitalize/DNR, etc.) Recommendations for situation may include EMS, ER (emergency room), call Regional	02320		

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02320	Continued From page 10 On-Call for direction, at home monitoring including increasing HHA visits, recheck vital signs, advise aide to call back with any change in condition. EMS: determine if client/caregiver need assistance in calling EMS ER: determine who will drive client to ER Call emergency contact in priority order and/or Hospice unless otherwise indicated in chart. Provide staff guidance/interventions that align within the scope of the HHA capabilities The RN After Hours nurse will notify families/responsible party as part of the process and to be able to answer any questions. In the event the RN is unable to notify family/responsible party, the HHA will notify family. The licensee's Death of a resident policy dated May 2024, indicated to ensure the death of a client will be handled appropriately and professionally. Procedure: Call 911, report that you are calling with a death, non-emergency. Have the following information available for 911 dispatcher: Name of the deceased Address Time of discovery Code status Location where the client's body was discovered Any other circumstances staff know about why the client passed. 911 will provide further instructions; they may ask staff to stay near the body. The licensee's Resident Emergency Plan dated January 2023, indicated Medical Emergency if a resident or visitor becomes ill or has an accident in your apartment: Call 911 and give them information about the emergency.	02320		

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 08/30/2024

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

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02320	Continued From page 11 No further information was provided. Time period for correction: Seven (7) Days	02320		
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 and an individual person were responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		