Electronically Delivered

November 6, 2025

Licensee
The Towers
1011 Feltl Court
Hopkins, MN 55343

RE: Project Number(s) SL20217016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 25, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. 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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20217	A. BUILDING: _____ B. WING _____	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TOWERS	1011 FELTL COURT HOPKINS, MN 55343

(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: SL20217016-0 On September 22, 2025, through September 25, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 242 residents; 58 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 510 SS=D	144G.41 Subd. 3 Infection control program	0 510		

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0 510	Continued From page 1 (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (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 establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control related to hand hygiene and use of personal protective equipment (PPE) for one of two unlicensed personnel ((ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On September 23, 2025, at 9:15 a.m., during continuous observation, the surveyor observed	0 510		

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0 510	Continued From page 2 ULP-B go to room 319 where they provided medication assistance to R6 for their oral medications. During the time ULP-A was in R6's room, the surveyor did not observe any hand hygiene before or after ULP-A provided cares or had contact with R6. ULP-B left R6's room and went to room 608 where they provided medication assist to R5 for their oral medication of MiraLAX. ULP-B got the medication tote from R5's cupboard, went into R5's refrigerator for juice, then proceeded to rinse their hands in R5's sink without using any soap. ULP-B then prepared the powered medication into a glass with water. After the administration of the MiraLax, ULP-B rinsed the glass with water in the sink without using soap and did not wash their hands with soap. ULP-B left R5's room, failed to perform hand hygiene, and entered other residents' rooms to check on them. ULP-B went to room 135, knocked on door but no response. ULP-B stated the resident was hard of hearing, so they needed to go inside. ULP-B grabbed and unlocked the medication tote. ULP-B rinsed their hands in the sink with water but did not use any soap. ULP-B then proceeded to review medications and set up the oral medications for administration. ULP-B gave the cup of medications to the resident, then reached in the resident's refrigerator to get a bottle of water out for the resident. ULP-B then put gloves on without performing hand hygiene while they observed the resident take their medications. ULP-B then told the resident it was time for their eye drops. The resident sat down in a recliner and put their head back. ULP-B got a tissue from the resident's tissue box and handed to the resident. ULP-B then applied one drop of the resident's medication in each eye. After the administration of the eye drops, ULP-B	0 510		

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0 510	Continued From page 3 documented the administration of the medications and then proceeded to remove the gloves after. ULP-B did not perform hand hygiene upon leaving the resident room. On September 23, 2025, at 11:18 a.m., ULP-B stated hand hygiene and glove use was the first thing they taught in school and on the job. ULP-B stated if you see something visibly dirty, you must put gloves on and then wash your hands. Also, ULP-B stated they would use gloves any time they have personal contact, or with applying eye drops or lotion. The surveyor asked ULP-B if they should have performed hand hygiene after the procedure of administering eye drops. ULP-B stated they used gloves. ULP-B's Skill #1: Handwashing dated January 13, 2020, indicated ULP-B had passed an evaluation by a registered nurse. ULP-B's Skill #2: Alcohol-based Hand Rub dated January 13, 2020, indicated ULP-B had passed an evaluation by a registered nurse. ULP-B's Skill #3: Putting on (Donning) and Removing Gloves Check Off dated January 13, 2020, indicated ULP-B had passed an evaluation by a registered nurse. On September 23, 2025, at 11:57 a.m., regional clinical director (RCD)-F stated handwashing should occur before and after resident cares no matter if they had used gloves; and hand washing should be performed before and after the use of gloves. RCD-F stated the staff usually would not use gloves with oral medication administration unless needed. RCD-F stated the licensee preferred the staff to wash hands using	0 510		

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0 510	Continued From page 4 soap and water unless the resident did not want the staff to use their soap, then they could use hand sanitizer. RCD-F stated the ULPs have access to hand sanitizer. RCD-F stated it would be good for the staff to carry this on them, and they did not know if this had been encouraged at the facility but would check as they were not always on site. On September 23, 2025, at 12:54 p.m., RCD-F stated the had confirmed with clinical nurse supervisor (CNS)-D, the licensee did provide individual sanitizer and soap to staff. RCD-F stated they will need to change the process to get hand sanitizer and soap to staff so they are not having to look for this; and the licensee will need to provide more education to staff. RCD-F stated this was a good thing to become aware of for this facility. The Hand Hygiene policy dated July 23, 2021, indicated hand washing shall be performed before and after direct contact with a resident; if moving from a contaminated body site to a clean body site during client care; after removing gloves or gowns; and before eating and after using a restroom. Also, the policy indicated the use of gloves did not replace hand washing. The licensee's Procedure for Using Gloves policy dated July 23, 2021, indicated gloves were to be worn whenever there may be direct contact between the caregiver's hands and blood, body fluids, secretions, feces, or a contaminated item, such as soiled linens or wound dressings. The policy indicated under the procedure, hand washing was to be performed before and after the use of gloves.	0 510		

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0 510	Continued From page 5 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the employee record contained the required content for two of two unlicensed personnel ((ULP)-A,	0 650		

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0 650	Continued From page 6 ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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-A ULP-A was hired on March 26, 2024. ULP-A's employee record lacked evidence of competency evaluation by a registered nurse to determine if ULP is competent to follow the procedures for giving medications to residents for unplanned time away from the facility. On September 23, 2025, at 8:40 a.m., ULP-A stated they were not trained by the nurse for unplanned times away. ULP-A stated only the nurse would provide medications to residents in an unplanned time away as they would only administer medications from the medication administration record and not pack up any medications for the resident. ULP-B ULP-B was hired on February 27, 2006. ULP-B's employee record lacked evidence of competency evaluation by a registered nurse to determine if ULP is competent to follow the procedures for giving medications to residents for	0 650		

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0 650	Continued From page 7 unplanned time away from the facility. On September 23, 2025, at 11:18 a.m., ULP-B stated they were trained by a nurse for unplanned times away. ULP-B stated when we have a resident with an unplanned time away, we would call the nurse for approval to give the medications to the resident. ULP-B stated they would put the medications in small envelopes with the date and time. ULP-B stated this did not happen often. On September 24, 2025, at 12:35 p.m., regional clinical director (RCD)-F provided a course syllabus for Medication Administration and stated this is the training the licensee provided during their class training by corporate. RCD-F stated they realized their documentation did not include a competency evaluation for unplanned time away when ULP-A had the training. RCD-F stated they did update the licensee's competency forms going forward to include the documentation of the competency for unplanned time away. On September 24, 2025, at 2:15 p.m., RCD-F stated the licensee had reached out to Educare (common online training platform) and got the facilitator guide and Educare test for ULP-B. RCD-F stated this training was provided to ULP-B. On September 24, 2025, at 3:00 p.m., RCD-F stated the licensee trained on unplanned time away at their corporate class, but the nurse did not have this on the check off for competencies, therefore it is not very clear. RCD-F stated the licensee should have the competency in their documentation. RCD-F confirmed the records for ULP-A and ULP-B lacked the documentation for	0 650		

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0 650	Continued From page 8 unplanned time away. The licensee's Personnel Records policy dated January 26, 2023, indicated the personnel record would include documentation of all required training for unlicensed personnel and competency determinations. Minnesota Administrative Rule 4659.0190, subpart 6, A., dated August 11, 2021, indicated the facility must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic: - facility name, location, and license number; - name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; - date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; - name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and - name and title of the staff person completing the training, and the staff person's signature with a statement attesting that the staff person successfully completed the training as described in the training documentation. No further information was provided.	0 650		

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0 650	Continued From page 9 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned	0 780		

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0 780	Continued From page 10 and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 23, 2025, from 10:00 a.m. to 1:30 p.m., the surveyor toured the facility with director of maintenance (DOM)-H, licensed assisted living director (LALD)-C, assistant assisted living director (AALD)-E, and regional director of operations (RDO)-G. Upon testing, the smoke alarms in the following locations were not interconnected: - Apartment 523 - Apartment 324 - Apartment 316 - Apartment 243 The following location lacked a smoke alarm as required: - Apartment 411 was missing a smoke alarm in bedroom 2. - Apartment 120 was missing a smoke alarm in the bedroom. The following locations had improperly installed	0 780		

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0 780	Continued From page 11 smoke alarms: - Apartment 120 and 135 had smoke alarms install more than 12 inches from the ceiling. These deficient conditions were visually verified at the time of discovery by DOM-H accompanying on the tour. On September 23, 2025, at 11:30 a.m., DOM-H stated they planned to replace the battery powered smoke alarms with hardwired smoke alarms (alarms receiving power from the building electrical system). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date	01060		

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01060	Continued From page 12 or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative for one of two 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 a widespread scope (when	01060		

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01060	Continued From page 13 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: R4 was admitted to the licensee on June 14, 2024, with a diagnosis of chronic kidney disease status post kidney transplant. R4's Service Plan Agreement dated August 11, 2025, indicated R4 received assistance with treatment of compression stockings every morning and every evening. R4's progress notes dated June 22, 2024, at 10:34 a.m., indicated R4's home care agency sent R4 to emergency room during their home care visit due to R4's inability to care for themself. R4 had an emergency relocation due to an urgent medical need. R4's record lacked documentation of R4 or R4's designated representative received a written emergency relocation notice with all required content for each emergency relocation. On September 24, 2025, at 2:21 p.m., regional clinical director (RCD)-F stated the licensee did not have an emergency relocation for R4 since R4 was sent to emergency room by home care. RCD-F stated the licensee's social worker had previously called a consulting company and were told the licensee did not need to provide an emergency relocation notice when the licensee did not initiate the emergency relocation. The surveyor explained Minnesota Statute 144G.52 Subd 9. to the licensee. RCD-F then stated the Statute indicated only if the facility initiated the	01060		

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01060	Continued From page 14 emergency relocation. The surveyor then showed the licensee the written Statute to show it indicated a facility may remove a resident from the facility in an emergency but in the event of an emergency relocation, the facility must provide a written notice. RCD-F stated they had misunderstood the Statute. The licensee's Contract Termination policy dated May 26, 2025, indicated the licensee would provide a written notice that contained all the required information in the event of an emergency relocation. The policy indicated the written notice would be delivered as soon as possible to the resident, legal representative, designated representative, the residents case manager if the resident received community-based waiver services, and the Office of Ombudsman for Long-Term Care (OOLTC) if the resident had not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on	01620		

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01620	Continued From page 15 which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective	01620		

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01620	Continued From page 16 resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure reassessment and monitoring were completed no more than fourteen calendar days after initiation of services; and ongoing resident reassessment and monitoring were completed as needed based on changes in the needs of the resident but not to exceed 90 calendar days from the last date of assessment for three of three residents (R4, R5, R6). 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: R4 R4 was admitted to the licensee on June 14, 2024. R4's Service Plan Agreement dated August 11, 2025, indicated R4 received assistance with treatment of compression stockings every morning and every evening. R4's record included a fourteen-day assessment dated July 9, 2024; and ninety-day assessments dated February 11, 2025, May 9, 2025, and	01620		

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01620	Continued From page 17 August 8, 2025. The fourteen-day assessment dated July 9, 2024, was completed twenty-five days after the start of services. The ninety-day assessment dated August 8, 2025, indicated it was completed 91 days after the previous assessment dated May 9, 2025. R5 R5 was admitted to the licensee on June 19, 2024. R5's Service Plan Agreement dated August 21, 2025, indicated R5 received assistance with medication administration. R5's record lacked a fourteen-day assessment after the start of services. R6 R6 was admitted to the licensee on April 22, 2025. R6's Service Plan Agreement dated September 23, 2025, indicated R6 received assistance with medication administration. R6's progress notes dated April 22, 2025, at 10:03 a.m., indicated the RN had completed a medication set up, which indicated R6 had begun to receive assisted living services on April 22, 2025. R6's record included a fourteen-day assessment dated June 9, 2025, and a ninety-day assessment dated September 9, 2025. The fourteen-day assessment dated June 9, 2025, was completed forty-eight days after the start of services. The ninety-day assessment dated September 9, 2025, indicated it was completed	01620		

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01620	Continued From page 18 92 days after the previous assessment dated June 9, 2025. On September 24, 2025, at 2:57 p.m., regional clinical director (RCD)-F stated R5's fourteen-day assessment was missed. RCD-F stated the licensee had a new director and could not ask the previous director. RCD-F stated the licensee did not have a system for reminders, but this has been implemented. RCD-F stated they can now generate a report to know when an assessment is due, but it will be making sure the system is followed. The licensee's Initial and On-going Nursing Assessment of Residents Under the Comprehensive Licensed Agency policy dated October 27, 2021, indicated a fourteen-day assessment would be completed up to fourteen days after the start of services; and ongoing assessment would be completed periodically but no less then every ninety days. The policy failed to indicate a reassessment would need to be completed at least every ninety days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
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	01760		

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01760	Continued From page 19 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 license failed to ensure medication administration was documented accurately for one of two residents (R6). 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: On September 23, 2025, at 9:15 a.m., the surveyor observed unlicensed personnel (ULP)-B assist R6 with medication administration. During the medication administration, the surveyor observed ULP-B administered R6's carbidopa/L-dopa 25/100 milligrams (mg) one tablet to R6. After ULP-B assisted R6 with medication administration, ULP-B documented on R6's Medication/Treatment Sheet ((medication administration record) MAR) to indicate they had administered carbidopa/L-dopa	01760		

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01760	Continued From page 20 25/100 mg one tablet and carbidopa/L-dopa 25/100 mg one and half tablets. On September 23, 2025, at 11:29 a.m., the surveyor reviewed R6's medications stored in R6's apartment. The surveyor verified R6 only had one medication bubble pack from the pharmacy for carbidopa/L-dopa 25/100mg take one tablet by mouth once daily. R6 was admitted to the licensee on April 16, 2025. R6's Service Plan Agreement dated September 23, 2025, indicated R6 received assistance with medication administration. R6's Medication/Treatment Sheet (MAR) dated September 2025, indicated the following medications were administered September 1, 2025, through September 23, 2025: Carbidopa/L-dopa 25-100 mg tab, take one tablet by mouth once daily at 8:00 a.m.; and Carbidopa/L-dopa 25-100 mg tab, take one and half tablets by mouth daily. Under Time the MAR indicated Other and did not include an exact time to be given. R6's prescriber orders dated August 29, 2025, indicated to discontinue previous Sinemet (brand name for carbidopa/L-dopa) order and start Sinemet 25/100mg one tablet per oral every day. On September 23, 2025, at 11:57 a.m., regional clinical director (RCD)-F confirmed the staff were not documenting on the MAR correctly. RCD-F stated the previous carbidopa/L-dopa 25/100 mg, take one and half tablets should have been discontinued on the MAR. RCD-F stated the	01760		

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01760	Continued From page 21 nurse who got the order and implemented the change did not realize the licensee also had a paper MAR in the resident apartments. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel dated July 28, 2021, indicated medications always need to be administered according to the "6 Rights" (right person, right medication, right time, right route, right dose, right chart/record to document that the medication was taken). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=E	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of medication setup included all the required content for two of three residents (R5, R6). 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 pattern scope (when more than a	01770		

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01770	Continued From page 22 limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R5 R5 was admitted to the licensee on June 19, 2024. R5's Service Plan Agreement dated August 21, 2025, indicated R5 received assistance with medication administration and medication set up. R5's progress notes dated July 28, 2025, at 12:38 p.m. indicated medications reviewed and set up for August. R5's progress notes dated August 25, 2025, at 6:27 p.m., indicated medications reviewed and set up for September. R5's record lacked documentation of name of medications, quantities of dose, times to be administered, and routes of administration at the time of the medication setup. R6 R6 was admitted to the licensee on April 16, 2025. R6's Service Plan Agreement dated September 23, 2025, indicated R6 received assistance with medication management that included complex medication for set up and medication administration. R6's progress notes dated July 28, 2025, at 1:08	01770		

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01770	Continued From page 23 p.m., indicated medications reviewed and set up for August. R6's progress notes dated July 29, 2025, at 2:28 p.m., indicated Genvoya was set up in cold seal pack for August. R6's progress notes dated August 18, 2025, at 11:07 a.m., indicated aspirin and Genvoya was set up on cold seal packs for September. R6's progress notes dated August 25, 2025, at 6:10 p.m., indicated medications reviewed and set up for September. R6's record lacked documentation of name of medications, quantities of dose, times to be administered, and routes of administration at the time of the medication setup. On September 22, 2025, at 10:26 a.m., during the entrance conference, clinical nurse supervisor (CNS)-D stated the licensee's medication set up services included the nurse setting up medications weekly in medication pill boxes and then documenting the service in the licensee's electronic medical record progress note. On September 25, 2025, at 3:30 p.m., regional clinical director (RCD)-F confirmed the licensee had not been following the statue when they were not setting up the medications in a medication pill box. RCD-F confirmed the licensee did not retain the cold seal medication blister pack card setup by the licensee's nurse for documentation of the medication setup in the clinical record.	01770		

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01770	Continued From page 24 The licensee's Medication Administration System - dosage box set-up policy dated May 26, 2025, indicated after the nurse had completed setting up medications into a dosage box, they would document each individual medication set up on the medication administration record (MAR)/electronic medication administration record (EMAR) or other section of resident's legal medical record. The policy did not indicate the required documentation per statue to include documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. The policy did not address situations of the nurse performing a medication setup other than a dosage box such as a cold seal medication blister pack card. MN Statue 144G.08 Subd 41, Medication Setup, reads, "Medication setup" means arranging medications by a nurse, pharmacy, or authorized prescriber for later administration by the resident or by facility staff. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided	01910		

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01910	Continued From page 25 for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include quantity and names of staff and other individuals involved in the disposition of medications for one of two discharged residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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 Discharge Summary dated May 6, 2025, indicated R1 was admitted to the licensee on	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20217	A. BUILDING: _____ B. WING _____	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TOWERS	1011 FELTL COURT HOPKINS, MN 55343

(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
01910	Continued From page 26 August 1, 2023, and discharged on May 5, 2025, to another assisted living license with dementia care due to increased needs and R1's goal to remain with their spouse. Also, under Status of Medications Upon Discharge, indicated the medications were to remain in the possession of the company for continued support in another building that had a different health facility identification. R1's record lacked evidence of documentation of disposition of medications to include the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. On September 22, 2025, at 1:00 p.m., regional clinical director (RCD)-F confirmed R1 did not have documentation of the medication disposition in R1's record. RCD-F stated R1 was discharged to another facility with a different license but owned by the same company. RCD-F stated the staff were not aware they needed to complete a medication disposition when they transferred a resident within the same company as they did not realize they had separate licenses. The licensee's Disposition or Disposal of Medication policy dated January 23, 2023, indicated a resident's current medications that are secured or stored by the licensee would be given to the resident or the resident's representative when the resident's medication management services were terminated; and staff would document in the resident's record the name of the person to whom the medications were given, the time and date, the name of each	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01910	Continued From page 27 medication and the amount of medication remaining. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01910		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure written or electronic treatment orders were maintained for one of one resident (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:	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20217	A. BUILDING: _____ B. WING _____	09/25/2025

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THE TOWERS	1011 FELTL COURT HOPKINS, MN 55343

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01970	Continued From page 28 On September 23, 2025, at 8:50 a.m., the surveyor observed unlicensed personnel (ULP)-A apply compression stockings (garments that apply gentle pressure used to help improve blood flow, reduce pain and swelling, and prevent conditions like blood clots) to R4's bilateral lower extremities. R4 was admitted to the licensee on June 14, 2024, with diagnoses of chronic kidney disease status post kidney transplant and personal history of venous thrombosis and embolism (blood clot). R4's Service Plan Agreement dated August 11, 2025, indicated R4 received assistance with treatment of compression stockings every morning and every evening. R4's record lacked a written or electronic order authenticated by R4's provider for the treatment of compression stockings. On September 24, 2025, at 2:15 p.m., regional clinical director (RCD)-F stated the licensee was not able to locate an order for R4's compression stockings. On September 25, 2025, at 11:35 a.m., RCD-F stated they had talked to R4 as the nurse who had completed R4's assessment was not available. RCD-F stated R4 had told them R4's provider had recommended the compression stocking but never prescribed them. RCD-F stated the compression stockings were more like diabetic stockings. The surveyor reviewed the definition in Statute for treatments with RCD-F, who then agreed they should have gotten an order for the compression stockings.	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01970	Continued From page 29 The licensee's Resident Records policy dated July 28, 2021, indicated the resident record would contain orders or prescriptions for treatments the licensee would be managing. MN Statue 144G.08 Subd 71, Treatment or Therapy, reads, "Treatment" or "Therapy" means the provision of care, other than medications, ordered or prescribed by a licensed health professional and provided to a resident to cure, rehabilitate, or ease symptoms. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

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

THE TOWERS
1011 FELTL COURT
Hopkins, MN 55343
Hennepin County
Parcel:

Phone:

License Info

License: HFID 20217

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1004251162
Inspection Type: Full - Single
Date: 9/22/2025 Time: 1:00:00 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

ESTABLISHMENT IS SERVICED BY A 3RD PARTY (UNIDINE) FOOD SERVICE PROVIDER AND IS LICENSED THROUGH THE LOCAL DELEGATED AGENCY. NO INSPECTION WAS CONDUCTED DURING THE HEALTH REGULATIONS DIVISION SURVEY.

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 F1004251162 from 9/22/2025

Molly Dougherty

Establishment Representative

Molly Dougherty,
Public Health Sanitarian 3
651-201-3978
molly.dougherty@state.mn.us