Electronically delivered

June 22, 2022

Administrator
Towerlight On Wooddale Avenue
3601 Wooddale Avenue South
Saint Louis Park, MN 55416

RE: Project Number(s) SL28790015

Dear Administrator:

On June 2, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on March 8, 2022. The follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the March 8, 2022 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on March 8, 2022, found not corrected at the time of the June 2, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

1500-Required Annual Training-144g.63 Subd. 5
1530-Training In Dementia Care Required-144g.64
1620-Initial Reviews, Assessments, And Monitoring-144g.70 Subd. 2 (c-E)

The details of the violations noted at the time of this follow-up evaluation completed on June 2, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:
Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in

§144G.20 for widespread violations;

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

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

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970
Health.HRD.Appeals@state.mn.us

We urge you to review these orders carefully. If you have questions, please contact Jonathan Hill at 651-201-3993.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Jonathan Hill, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28790	A. BUILDING: _____ B. WING _____	R 06/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWERLIGHT ON WOODDALE AVENUE	3601 WOODDALE AVENUE SOUTH SAINT LOUIS PARK, MN 55416

(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 Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: Project # SL28790015-1 On May 31, 2022, through June 2, 2022, the Minnesota Department of Health conducted a desk review with the above provider to follow-up on orders issued pursuant to a survey completed on March 8, 2022. At the time of the survey, there were 54 residents receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living with Dementia Care 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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{0 800}	Continued From page 1	{0 800}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: No further action required	{0 800}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in	{0 810}		

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{0 810}	Continued From page 2 their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required	{0 810}		
{01500} SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment;	{01500}		

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{01500}	Continued From page 3	{01500}		

disinfecting environmental surfaces; and reporting communicable diseases;
(4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;
(5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and
(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.
(b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:
(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;
(2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or
(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure employees received at

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{01500}	Continued From page 4	{01500}		

least eight (8) hours of annual training for each 12 months of employment for one of three employees (unlicensed personnel (ULP)-K) with employee records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).

The findings include:

ULP-K started employment on February 9, 2021, under the comprehensive home care license and began providing assisted living services on August 1, 2021.

The licensee's employee schedule for May 2022, indicated ULP-K worked May 1, 6, 11, 13-15, 18, 20, 25, and 27-30, 2022.

R7's medication administration record for May 2022, indicated ULP-K assisted R7 with medication administration May 13, 2022, and May 20, 2022.

ULP-K's employee record indicated 2.5 hours of the 8 hours of required annual training was completed in the last 12 months. ULP-K's employee record lacked evidence of annual training topics completed to include:
-training on reporting of maltreatment of vulnerable adults under section 626.557;
-review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing

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{01500}	Continued From page 5	{01500}		

techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases.

On June 2, 2022, during a 12:04 p.m. interview, registered nurse (RN)-A stated the licensee's education department assigned all annual education to employees through the online system at beginning of the year. RN-A further stated it was her understanding that employees had until December 31 to complete annual training.

The licensee's "Required Training - Annual/Biannual" policy, revised January 2022, indicated, "All staff that perform direct services will complete at least eight hours of annual training for each 12 months of employment". The policy further indicated annual training would include the following topics:

-Reporting of maltreatment of vulnerable adults;

-Assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;

-Infection control techniques used in the home and implementation of infection control standards;

-Effective approaches to use to problem solve when working with a resident's challenging behaviors;

-Effective approaches for communication with residents who have dementia, Alzheimer's disease, or related disorders;

-Review of the facility's policies and procedures relating to the provision of assisted

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{01500}	Continued From page 6 living services and how to implement them; -Principles of person-centered planning and service delivery; -How person-centered planning and service delivery applies to direct support services provided by staff; and -Emergency and disaster training. No further information was provided.	{01500}		
{01530} SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;	{01530}		

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{01530}	Continued From page 7 This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure the required amount of dementia care training was completed in the required time frame in accordance with 144G.64 for one of four employees (unlicensed personnel (ULP)-K) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-K started employment on February 9, 2021, under the comprehensive home care license and began providing assisted living services on August 1, 2021. The licensee's employee schedule for May 2022, indicated ULP-K provided cares to residents May 1, 6, 11, 13-15, 18, 20, 25, and 27-30, 2022. R7's medication administration record for May 2022, indicated ULP-K assisted R7 with medication administration May 13, 2022, and May 20, 2022. ULP-K's employee record indicated 0.75 hours of the required 2 hours of dementia care training was completed within the last 12 months of employment.	{01530}		

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{01530}	Continued From page 8 On June 2, 2022, during a 12:04 p.m. interview, registered nurse (RN)-A stated the licensee's education department assigned all annual education to employees through the online system at beginning of the year. RN-A further stated it was her understanding that employees had until December 31 to complete annual training. The licensee's "Dementia-Specific Training" policy, revised May 2022, indicated, "[Licensee] staff is expected to complete dementia specific training as required by regulations and job function. The training is developed and/or approved with the input from the Dimensions Program Coordinator." No further information provided.	{01530}		
{01620} SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) 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.	{01620}		

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{01620}	Continued From page 9 (e) 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 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 the registered nurse (RN) conducted a resident reassessment not to exceed 14 calendar days from the initiation of services for one of four residents (R9) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R9 was admitted May 12, 2022, and had diagnoses to include alcohol dependence, adult failure to thrive, and depression. R9's service plan, dated May 18, 2022, indicated R9 received services to include assistance with medication administration, shower, dressing, activities of daily living (ADLs), laundry and toileting. R9's record included an initial assessment completed May 12, 2022, and a 14-day	{01620}		

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{01620}	Continued From page 10 reassessment completed May 28, 2022 (16 days after start of services). On June 2, 2022, during a 12:04 p.m. interview, RN-A acknowledged the reassessment was completed greater than 14 days after R9 started receiving services. RN-A stated the RN who performed the assessment is "very good" at completing assessments on time and did not know why the assessment was not done within 14 days. RN-A further stated possibly the RN did the assessment on time and documented it late, or possibly R9 refused the initial attempt at reassessment. The licensee's Assessment of Clients - Initial and Ongoing policy reviewed May 23, 2022, indicated, "Resident reassessment and monitoring will be conducted no more than 14 calendar days after initiation of services. Ongoing client reassessment and monitoring will be conducted as needed, based on changes in the needs of the client and not to exceed 90 calendar days from the client's last date of the uniform assessment." No further information was provided.	{01620}		
{02040} SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and	{02040}		

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{02040}	Continued From page 11 (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: No further action required	{02040}		

Electronically Delivered

March 30, 2022

Administrator
Towerlight On Wooddale Avenue
3601 Wooddale Avenue South
Saint Louis Park, MN 55416

RE: Project Number(s) SL28790015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on March 8, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

The enclosed State Form documents the state licensing orders. The Department of Health 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 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 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services = $3,000.00

The total amount you are assessed is $3,000.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 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 the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:	Free from Maltreatment reconsideration requests should addressed to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: (651) 201-3993 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28790	A. BUILDING: _____ B. WING _____	03/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWERLIGHT ON WOODDALE AVENUE	3601 WOODDALE AVENUE SOUTH SAINT LOUIS PARK, MN 55416

(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 Initial comments *****ATTENTION****** ASSISTED LIVING 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: SL28790015 On March 7 through March 8, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 91 residents with 51 receiving services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living with Dementia Care 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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0 630	Continued From page 1	0 630		
0 630 SS=E	144G.42 Subd. 6 Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include statements of the specific measures to be taken to minimize the risk of abuse for four of five residents (R1, R2, R3, R5) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a 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: R1 R1 was admitted January 27, 2022. R1's diagnoses included chronic atrial fibrillation	0 630		

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0 630	Continued From page 2 and unspecified epilepsy. R1's Service Plan Agreement dated January 28, 2022, indicated R1 was receiving services to include assessment, shower, dressing/undressing, grooming assistance, medication administration, escort, safety checks, and catheter care. R1's Vulnerabilities and Abuse Prevention dated February 4, 2022, indicated R1 had vulnerabilities to include history of fall, use of four wheeler walker, and unsteady gait. R1's IAPP lacked specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. R2 R2 was admitted April 7, 2017, under the comprehensive home care license, and began receiving assisted living services on August 1, 2021. R2's Service Plan Agreement dated January 1, 2022, indicated R2 received services for nursing assessments, activities, bathing, dressing, grooming, laundry, medication administration, escort, transfer assistance, toileting assistance and safety checks. R2's Vulnerability: Safety and Risk assessment dated September 30, 2021, indicated R2 was vulnerable to others and unable to report abuse or neglect. R2's IAPP lacked specific measure to be taken to minimize the risk of abuse or neglect to R2. R3	0 630		

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0 630	Continued From page 3 R3 was admitted February 21, 2022. R3's record included an assisted living contract, signed February 21, 2022. R3's record lacked and IAPP to include an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults On March 7, 2022, at approximately 2:18 p.m., resident services coordinator (RSC)-G confirmed R3 did not have an IAPP. RSC-G stated the IAPP should be completed at the time the contract is signed. R5 R5 was admitted November 15, 2016, under the comprehensive home care license, and began receiving assisted living services on August 1, 2021. R5's record included an acknowledgement of receipt of an assisted living contract, signed July 27, 2021. R5' record lacked an IAPP to include an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On March 8, 2022, at approximately 9:20 a.m.	0 630		

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0 630	Continued From page 4 registered nurse (RN)-A acknowledged the licensee did not develop an IAPP for R5 to include statements of the specific measures to be taken to minimize risk of abuse or neglect to the resident. The licensee's Vulnerable Adult Reporting and Investigation policy dated March 1, 2014, and reviewed December 2, 2020, indicated staff would be trained on the Vulnerable Adult Act and the reporting policy; the policy lacked verbiage to include requirement for individual resident assessment to include content noted above. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	0 640		

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0 640	Continued From page 5 failed to support protection and safety by not posting the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all ninety-one (91) 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 7, 2022, at approximately 11:45 a.m. during a facility tour, the surveyor observed the facility's common areas and noted no postings of the 911 emergency number. On March 8, 2022, at 10:02 a.m. the 2nd floor nursing office area was observed and lacked posting of the 911 emergency number. On March 8, 2022, at 10:33 a.m. licensed practical nurse (LPN)-I verified the 911 emergency number was not posted on the 2nd floor. On March 8, 2022, at 11:07 a.m. registered nurse (RN)-A acknowledged the 911 emergency number was not posted in common areas of the facility. RN-A indicated the direction for staff to call 911 for emergencies was located in the emergency preparedness handbook.	0 640		

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0 640	Continued From page 6 A policy regarding required posting of 911 emergency numbers was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (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. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with	0 650		

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0 650	Continued From page 7 the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employee records included all required content for two of three employees (unlicensed personnel (ULP)-B, ULP-F) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B ULP-B employee record lacked current job description. ULP-B started employment on July 19, 2021, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On March 8, 2022, at approximately 12:27 p.m., the surveyor observed ULP-B pass medications to assisted living resident (R8). On March 8, 2022, at approximately 11:25 a.m., licensed assisted living director (LALD)-D stated the licensee misplaced ULP-B's previous job	0 650		

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0 650	Continued From page 8 description, and provided a document titled Position/Job Description Receipt dated March 8, 2022, during the time of the survey. ULP-F ULP-F's employee record lacked current job description and annual reviews. ULP-F started employment on October 19, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On March 8, 2022, at approximately 8:45 a.m., the surveyor observed ULP-F pass medications to R1. On March 8, 2022, at approximately 1:58 p.m., registered nurse (RN)-A, provided a document titled Position/Job Description Receipt dated March 8, 2022, during the time of the survey. During an interview on March 8, 2022, at approximately 3:40 p.m., LALD-D, RN-A and RN-H acknowledged the employee record was missing required content noted above. The Licensee's Employee Records/File policy dated July 2004, and revised January 2020, indicated employee record will contain the content noted missing above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 9 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to maintain a written emergency disaster preparedness plan with all the required content. This had the potential to affect staff, visitors and all 91 residents receiving services under the assisted living facility with dementia care license. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 680		

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0 680	Continued From page 10 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 7, 2022, at approximately 10:50 a.m. the licensee's emergency preparedness (EP) plan was requested and provided. The licensee's EP plan lacked the following content and/or policies and procedures to address: - Procedures for Tracking of Staff and Patients - Policies and Procedures for Medical Documents - Roles under a Waiver Declared by Secretary - Primary/Alternate Means for Communication - Methods for Sharing Information On March 8, 2022, at approximately 3:40 p.m. registered nurse (RN)-A, and licensed assisted living director (LALD)-D acknowledged licensee's EP plan lacked the required content as noted above. The licensee's EP policy was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800		

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0 800	Continued From page 11 (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. 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) 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 residents). The findings include: On March 7, 2022, from approximately 1:15 p.m. to 2:30 p.m., survey staff toured the facility with the director of maintenance (DM)-C. During the facility tour, survey staff observed the following: 1. The fifth-floor trash chute did not latch. 2. The sprinkler head in the family lounge storage closet was obstructed. 3. The bathroom fan in room 500 did not work.	0 800		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 12 DM-C verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees	0 810		

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	28790	A. BUILDING: _____ B. WING _____	03/08/2022

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0 810	Continued From page 13 twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the required fire safety training and evacuation plans for residents and staff. This has 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 residents). The findings include: On March 7, 2022, at 2:30 p.m. the director of maintenance (DM)-C stated the facility had not yet done any training for employees or residents on the fire safety and evacuation plans. A review of the fire safety manual showed the following: 1. No schedule or records on the training of employees on fire safety and evacuation; on proper actions to take in the event of a fire or emergency for the safety of residents including movement, evacuation, or relocation.	0 810		

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0 810	Continued From page 14 2. No schedule or records on the training of residents who are capable of assisting in their evacuation; on proper actions to take in the event of a fire or emergency for their safety including movement, evacuation, or relocation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37.	0 900		

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0 900	Continued From page 15 (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a written assisted living contract with the required content for one of five residents (R4) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: The facility converted to an Assisted Living license on August 1, 2021. The licensee failed to execute a written assisted living contract with the required content with R4 prior to providing housing or assisted living services. R4's service plan dated January 1, 2022, indicated R4 received services for assistance with	0 900		

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0 900	Continued From page 16 medication administration, bathing, assistance with activities of daily living (ADLs), dressing and grooming, transfers, toileting assistance, and laundry. R4's record lacked a current assisted living contract. On March 8, 2022, at 12:40 p.m. registered nurse (RN)-A verified the signed assisted living contract was not included in R4's record. A policy regarding the provision and required content of an Assisted Living contract was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
0 950 SS=E	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated	0 950		

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0 950	Continued From page 17 Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the opportunity to identify a designated representative for three of five residents (R2, R3, R4) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a 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: The facility converted to an Assisted Living license on August 1, 2021. R2 R2 admitted under the comprehensive home care license and began receiving assisted living	0 950		

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0 950	Continued From page 18 services on August 1, 2022. R2's contract dated August 1, 2021, lacked documentation R2 was given the opportunity to identify or to decline a designated representative. R3 R3 admitted for housing only. R3's contract dated February 21, 2022, lacked documentation R3 was given the opportunity to identify or to decline a designated representative. R4 R4 was admitted under the comprehensive home care license and began receiving assisted living services on August 1, 2022. R4's service plan dated January 1, 2022, indicated R1 received services for assistance with medication administration, bathing, assistance with activities of daily living (ADLs), dressing and grooming, transfers, toileting assistance, and laundry. R4's record lacked documentation R4 was given the opportunity to identify or to decline a designated representative. On March 7, 2022, at approximately 2:18 p.m. resident services coordinator (RSC)-G acknowledged R3 lacked documentation to identify or to decline a designated representative. RSC-G stated representative sheet had been mailed out to all residents, but they had not received all of the documentation back at the time of the survey. The licensee's Designated Representative policy was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		

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0 970 SS=F	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all 91 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 7, 2022, at approximately 1:00 p.m. a copy of the facility's assisted living contract was requested. The assisted living contract included two clauses that indicated the resident would waive the facility's liability for health, safety, or personal property of a resident. Page 14, section 26.0 of	0 970		

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0 970	Continued From page 20 the contract indicated the provider was not liable to resident's property damage occurring in the apartment unit or on provider's premises due to theft or actions of other residents. Page 18, section 31.0 of the contract indicated a resident would indemnify or hold harmless the provider, its employees and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by resident of the rented premises or any other part of the provider's property, or caused wholly or in part by an act or omission of resident or resident's guests or agents. On March 7, 2022, at approximately 3:55 p.m. licensed assisted living director (LALD)-D confirmed the assisted living contract required residents to waive the facility's liability for health, safety, or personal property. LALD-D confirmed the same assisted living contract was used for all residents at the facility. A policy regarding the provision and required content of an Assisted Living contract was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training	01500		

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01500	Continued From page 21 for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following	01500		

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01500	Continued From page 22 topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight (8) hours of annual training for each 12 months of employment for one of three employees (unlicensed personnel (ULP)-F) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-F started employment on October 19, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021.	01500		

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	28790	A. BUILDING: _____ B. WING _____	03/08/2022

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01500	Continued From page 23 On March 8, 2022, at approximately 8:35 a.m. ULP-F was observed passing medications to assisted living resident (R1). ULP-F's record lacked evidence of annual training to include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following	01500		

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01500	Continued From page 24 topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. On March 8, 2022, at approximately 3:50 p.m. licensed assisted living director (LALD)-D acknowledged annual training had not been completed for ULP-F. The licensee's Orientation and Training: Employee policy dated August 1, 2021, lacked content to address employee annual training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics	01530		

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01530	Continued From page 25 related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure the required amount of dementia care training was completed in the required time frame in accordance with 144G.64 for one of four employees (licensed assisted living director (LALD)-D) with records reviewed. This had the potential to affect all ninety-one (91) residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).	01530		

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01530	Continued From page 26 The findings include: LALD-D began employment on September 5, 2021, and provided supervisory services for the facility. LALD-D's employee record included documentation of two (2) hours of dementia care training completed December 28, 2020, and December 30, 2020. On March 8, 2022, at approximately 2:30 p.m. LALD-D provided documentation of 10.25 hours of dementia care training completed March 7, 2022, and March 8, 2022, during the assisted living licensure survey. On March 8, 2022, at 2:35 p.m. LALD-D verified dementia care training was completed during the survey. At approximately 2:45 p.m. LALD-D acknowledged the required eight (8) hours of dementia care training was not completed within 80 hours of working for the assisted living with dementia care licensed facility. The licensee's Staff Training-Dementia Care policy, dated August 1, 2021, indicated, "All [licensee] employees receive the same introduction to our approach to dementia care as part of New Employee Orientation. Dementia-related training topics at New Employee Orientation include: a. An explanation of Alzheimer's disease and other dementias b. Assistance with activities of daily living c. Problem solving with challenging behaviors d. Communication skills e. Person-centered planning and service delivery f. Understanding cognitive impairment and behavioral and psychological symptoms of	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28790	A. BUILDING: _____ B. WING _____	03/08/2022

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01530	Continued From page 27 dementia g. Standards of dementia care, including non pharmacological dementia care practices that are person-centered and evidence informed." No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	01530		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) 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. (e) 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 resident moves in, whichever is earlier. This MN Requirement is not met as evidenced	01620		

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	28790	A. BUILDING: _____ B. WING _____	03/08/2022

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01620	Continued From page 28 by: Based on interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment, not to exceed 90 calendar days from the last date of the assessment for two of five residents (R2, R4), in addition, licensee failed to complete a fall assessment for one of one resident (R2) receiving services with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a 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: 90-DAY R2 R2 admitted under the comprehensive home care license and began receiving assisted living services on August 1, 2022. The Service Plan Agreement dated January 1, 2022, indicated R2 received services for nursing assessments, activities, bathing, dressing, grooming, laundry, medication administration, escort, transfer assistance, toileting assistance and safety checks. R2's record included documentation of a comprehensive nursing assessment completed June 19, 2021, and September 30, 2021, greater than 90 days after previous assessment. R2's record lacked an assessment completed after	01620		

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01620	Continued From page 29 September 30, 2021. On March 8, 2022, at approximately 10:09 a.m. RN-A acknowledged R2's assessments exceeded 90 days. RN-A verified R2 had no assessment since September 30, 2021. R4 R4's service plan dated January 1, 2022, indicated R4 received services for assistance with medication administration, bathing, assistance with activities of daily living (ADLs), dressing and grooming, transfers, toileting assistance, and laundry. R4's record included documentation of a comprehensive nursing assessment completed July 21, 2021, and a reassessment completed December 25, 2021, greater than 90 days after the previous assessment. On March 8, 2022, at 12:40 p.m. RN-A verified R4's assessments were completed July 21, 2021, and December 25, 2021, and more than 90 days had passed between assessments. The licensee's Assessment of Clients - Initial and Ongoing policy updated August 1, 2021, indicated, "Ongoing client reassessment and monitoring will be conducted as needed, based on changes in the needs of the client and not to exceed 90 calendar days from the client's last date or the uniform assessment." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

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01650	Continued From page 30	01650		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident service plan included the required content for four of four residents (R2, R4, R5, R7) receiving assisted living services with records reviewed.	01650		

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01650	Continued From page 31 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R2's Service Plan Agreement dated January 1, 2022, indicated R2 received services for nursing assessments, activities, bathing, dressing, grooming, laundry, medication administration, escort, transfer assistance, toileting assistance and safety checks. R2's service plan lacked the methods of monitoring and resident assessments. R4 R4 was admitted under the comprehensive home care license, and began receiving assisted living services on August 1, 2021. R4's Service Plan Agreement dated January 1, 2022, indicated R4 received services for assistance with medication administration, bathing, grooming, meals, dressing, toileting and laundry. R4's service plan lacked the methods of monitoring and resident assessments.	01650		

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01650	Continued From page 32	01650		

R5
R5's Service Plan Agreement dated January 28, 2022, indicated R5 received services for covid screening, shower, nursing assessments, medication check, dressing, grooming, laundry, medication administration, escort, and safety checks.

R5's service plan lacked the methods of monitoring and resident assessments.

R7
R7's Service Plan Agreement dated December 17, 2021, indicated R7 received services for assistance with medication administration, bathing, grooming, meals, toileting and laundry.

R7's service plan lacked the methods of monitoring and resident assessments.

On March 8, 2022, at approximately 9:20 a.m. registered nurse (RN)-A acknowledged the resident service plans lacked a method of monitoring for resident assessments. RN-A verified the service plans did not indicate if assessment would occur over phone or face-to-face.

The licensee's Service Plan Agreement Development and Revision policy revised August 1, 2021, indicated, "A finalized service plan will be completed no later than 14 calendar days after initiation of services.
-The Service Plan Agreement is based upon the full individualized assessment(s) and a discussion with the client and/or the client's representative about the client's preferences and choices.
-The Service Plan Agreement is consistent with accepted standards of practice for professional nursing standards." The provided policy did not

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01650	Continued From page 33 address required content of the service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to dispose of expired medications for one of four residents (R8) receiving services with medication storage reviewed. 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: R8 admitted under the comprehensive home care license and began receiving assisted living services on August 1, 2022.	01890		

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01890	Continued From page 34 R8's Service Plan Agreement dated February 25, 2021, indicated R8 received services for activities, bathing, meals, dressing, grooming, nursing assessments, laundry, transfers and medication administration. R8 physician (prescriber) orders dated July 8, 2021, indicated R8's prescriptions included levothyroxine 7.5 milligrams (mg), quetiapine 25mg, sertraline 125mg, Tylenol 1000mg, and lorazepam 0.5mg as needed. On March 8, 2022, at approximately 12:27 p.m. the surveyor observed R8's medication cupboard that contained acetaminophen 500 mg bubble pack with expiration date of March 1, 2022. On March 8, 2022, at approximately 12:39 p.m. unlicensed personnel (ULP)-B confirmed R8's acetaminophen 500 mg expired on March 1, 2022. . The licensee's undated policy titled Medication Management, did not address expired medications. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written	01940		

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01940	Continued From page 35 statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R7) receiving treatment services with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an	01940		

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01940	Continued From page 36 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: R7 had diagnoses to include tachycardia (increased heart rate), and amnesia (loss of memory). On March 8, 2022, at 9:21 a.m. unlicensed personnel (ULP)-E was observed to assist R7 to apply compression stockings. R7's service plan dated December 17, 2021, indicated R7 received services to include assistance with medication administration, toileting, showering, grooming, meals, and laundry. R7's service plan did not include treatment services related to assistance with compression stockings. R7's record included a prescriber order signed January 26, 2022, which ordered, "Compression stockings 20-mmHg, bilateral, knee high, apply daily in AM and remove daily at HS [bed time]." R7's medication administration record for February 8, 2022, through March 8, 2022, indicated compression stockings were applied and removed daily, 27 out of 28 days. R7's record lacked an individualized treatment or therapy management plan addressing the use of compression stockings. On March 8, 2022, at approximately 1:15 p.m. RN-A acknowledged the compression stocking treatment was not included in R7's service plan.	01940		

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01940	Continued From page 37 RN-A verified an individualized treatment or therapy management plan was not developed for R7 regarding the delegated treatment. The licensee's Development of an Individualized Treatment or Therapy Management Plan policy revised August 1, 2021, indicated, "Following completion of the nursing assessment, including an assessment of the client's need for treatment management, the RN develops an individualized treatment management plan for the client in conjunction with the client and/or the client's representative, and educates the client and/or the client's representative on the individualized treatment management plan. The plan will address: -Identification of the treatment management services to be provided by our agency; -Identification of any specific client instructions regarding treatments our agency staff will administer; -Identification of the person responsible for monitoring any treatment supplies arc ordered on a timely basis. -Identification of the staff who are responsible for the treatment management tasks, including tasks delegated to unlicensed staff; -Procedure for staff to notify the nurse when there is a problem with any treatment management service; -Any client-specific requirements relating to documentation of treatment completion, verification that all treatments are administered as prescribed and monitoring of treatment use to prevent possible complications or adverse reactions." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01940		

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01940	Continued From page 38 days	01940		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct a hazard vulnerability or safety risk assessment on or around the facility property. 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) 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 residents). The findings include: During the interview on March 7, 2022, at 2:30 p.m., the director of maintenance (DM)-C stated	02040		

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02040	Continued From page 39 they had a hazard vulnerability assessment in the emergency preparedness finder. Review of the hazard vulnerability assessment showed global issues such as fire, gas leak, epidemic, and the active shooter had been identified. Local hazards that are site, building and population-specific had not been developed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02310 SS=G	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure the care and services were provided according to a suitable and up-to-date plan, and subject to acceptable health care and medical, or nursing standards for one of three residents (R2) with falls with records reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, 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	02310		

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TOWERLIGHT ON WOODDALE AVENUE	3601 WOODDALE AVENUE SOUTH SAINT LOUIS PARK, MN 55416

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02310	Continued From page 40 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's Master Assessment 2.0 dated September 30, 2021, indicated R2 was at high risk for falls, had decreased vision, unsteady gait, confusion, agitation, was on medications that may increase risk of falls, and resident should attend exercise class to increase strength and balance. R2's record included incident reports related to falls on October 10, 2021, November 12, 2021, November 29, 2021, and December 28, 2021. The incident reports and nursing notes included the following information: -October 10, 2021, fall occurred according to Fall Focused Nursing assessment. The staff-initiated fall flow sheet, notified family, notified physician, documented, reported off to nursing staff and completed neurological checks. The resident lacked an assessment of a change in condition, to include a root cause analysis of the residents falls. In addition, record lacked a new intervention based on change of condition assessment to prevent further falls. -November 12, 2021, at approximately 10:55 p.m. R2 was on the bathroom floor and had fallen into the shower. R2 sustained a head laceration that required 10 staples. Staff sent R2 to the hospital. The resident lacked an assessment of a change in condition, to include a root cause analysis of the residents falls. In addition, record lacked a new intervention based on change of condition assessment to prevent further falls. -November 29, 2021, at approximately 5:03 a.m. R2 had fallen and was sitting on floor behind door. R2 sustained a laceration to the elbow that required 14 stitches. Staff initiated fall flowsheet,	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28790	A. BUILDING: _____ B. WING _____	03/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWERLIGHT ON WOODDALE AVENUE	3601 WOODDALE AVENUE SOUTH SAINT LOUIS PARK, MN 55416

(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
02310	Continued From page 41	02310		

sent resident to hospital, notified family, notified, physician, completed nursing note, reported off to nursing staff and completed neurological checks. The resident lacked an assessment of a change in condition, to include a root cause analysis of the residents falls. In addition, record lacked a new intervention based on change of condition assessment to prevent further falls.
-December 28, 2021, at approximately 4:25 a.m. R2 had fallen and was sitting on floor against bed. R2 sustained no injury. Staff initiated fall flowsheet, notified family, notified physician, completed nursing note and reported to nursing team. The resident record lacked evidence an assessment of a change in condition, to include a root cause analysis of the residents falls, was completed. In addition, record lacked a new intervention based on change of condition assessment to prevent further falls.

R2's record lacked a change of condition assessment in response to falls on October 10, 2021, November 12, 2021, November 29, 2021, and December 28, 2021.

R2's service plan dated January 1, 2022, indicated fall interventions were updated on November 17, 2021. R2's new interventions included walker to be kept at beside on the side of bed closest to the bathroom. R2's service plan lacked service of exercise class. In addition, no further falls interventions were added for November 29, 2021, and December 28, 2021, falls.

On March 8, 2022, at approximately 10:09 a.m., RN-A stated the service plans were used as the resident's plan of care.

On March 8, 2022, at approximately 1:14 p.m.,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28790	A. BUILDING: _____ B. WING _____	03/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWERLIGHT ON WOODDALE AVENUE	3601 WOODDALE AVENUE SOUTH SAINT LOUIS PARK, MN 55416

(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
02310	Continued From page 42 RN-A confirmed R2 had falls on July 17, 2021, August 28, 2021, September 8, 2021, October 10, 2021, November 12, 2021, November 29, 2021, and December 28, 2021. RN-A also acknowledged a change of condition assessment had not been completed for R2 for dates listed above. RN-A confirmed the service plan and nursing notes lacked documentation of interventions put into place after falls based on the assessment. The licensee's Fall Protocol policy dated December 2, 2020, identified focused fall follow-up would be completed to determine additional interventions needed. In addition, the licensee's Assessment of Clients Initial and Ongoing policy dated August 1, 2021, indicates a RN would re-assess the resident with each change of condition and would revise the resident's service plan based on the resident assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *03/08/22*
Time: 10:00:00
Report: 8041221055

Food and Beverage Establishment Inspection Report

Location:
Towerlight On Wooddale Avenue
3601 Wooddale Avenue South
St Louis Park, MN55416
Hennepin County, 27

Establishment Info:
ID #: 0037969
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9528816322
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Utensil Surface Temp.: = at 160 Degrees Fahrenheit
Location: memory care kitchen
Violation Issued: No

Utensil Surface Temp.: = at 160 Degrees Fahrenheit
Location: main kitchen
Violation Issued: No

Acid/smart power: = 700 ppm at Degrees Fahrenheit
Location: sani bucket- main kitchen
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 189 Degrees Fahrenheit - Location: steam table: beef
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: front reach-in cooler: salad
Violation Issued: No

Process/Item: Cold Holding
Temperature: 35 Degrees Fahrenheit - Location: beverage reach-in cooler: milk
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: prep cooler: ham
Violation Issued: No

Type: Full
Date: *03/08/22*
Time: 10:00:00
Report: 8041221055
Towerlight On Wooddale Avenue

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: prep cooler: pancake batter
Violation Issued: No

Process/Item: Cold Holding
Temperature: 36 Degrees Fahrenheit - Location: walk-in cooler: potato pork soup
Violation Issued: No

Process/Item: Cold Holding
Temperature: 35 Degrees Fahrenheit - Location: walk-in cooler: cottage cheese
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: memory care cooler: milk
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	0

Inspection was completed with the chef, Alex Kisch. Renee Anderson was the lead RN with HRD completing site survey.

Establishment has a main kitchen on the first floor and a serving kitchen in memory care on the second floor.

Discussed the following:
Employee illness policy and logging requirements
Reporting foodborne illness complaints to MDH
Thermometer use and calibration
Cooling and re-heating procedures
Glove-use policy
Vomit/fecal clean-up procedures
Routine cleaning

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 8041221055 of 03/08/22.

Certified Food Protection Manager: Alex Ray Kisch

Certification Number: fm107145 Expires: 07/29/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Alex Kisch
Chef

Signed: Sarah Conboy
Sarah Conboy
Public Health Sanitarian III
651-201-3984
sarah.conboy@state.mn.us