Electronically Delivered

January 8, 2025

Licensee
Towerlight on Wooddale Avenue
3601 Wooddale Avenue South
Saint Louis Park, MN 55416

RE: Project Number(s) SL28790016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 5, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

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

HHH

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 _____	12/05/2024

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 ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL28790016-0 On December 2, 2024, through December 5, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 65 residents; 59 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee's written staffing plan failed to include an evaluation completed by a registered nurse at least twice a year. This had the potential to 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	0 470		

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0 470	Continued From page 2 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 facility tour on December 2, 2024, at approximately 12:30 p.m., the facility daily staffing schedule was noted to be posted at the front desk in a common area. The licensee's Facility Staffing Plan, undated, included an Additional Comments section that read "Done w/ Budget Review 2024 (for 2025). The staffing plan lacked evidence the plan had been evaluated twice per year and did not include authentication of who developed and reviewed it. On December 3, 2024, at approximately 4:15 p.m., licensed assisted living director (LALD)-A stated the staffing plan had not been reviewed twice per year and they were unaware of the requirement. The licensee's Staffing Plan policy revised May 1, 2022, indicated the Director of Health Services would develop, write, and implement a staffing plan and the staffing plan would be reviewed and revised as needed at a minimum of two times per year. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		

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0 480	Continued From page 3	0 480		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink;	0 480		

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0 480	Continued From page 4 (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated December 2, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24	0 480		

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0 480	Continued From page 5 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current State Fire Code	0 780		

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0 780	Continued From page 6 in Minnesota Rules, chapter 7511. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On December 5, 2024, from 10:00 a.m. to 1:30 p.m., the surveyor toured the facility with director of maintenance (DOM)-E. The surveyor made the following observations of non-compliance with current Minnesota Fire Code provisions: The trash chute door on the second floor inside the memory care unit's utility/laundry room did not shut and latch on its own. All trash chute doors should close and latch completely to maintain the fire resistance integrity of the trash chute system. The fire-rated laundry room doors on fourth floor and third floor did not close and positively latch on their own. Fire-rated doors to high-hazard spaces must close and positively latch to maintain the fire resistance integrity of the rated assembly. The fire-rated trash room door on third floor did not close and positively latch on its own. Fire-rated doors to high-hazard spaces must close and positively latch to maintain the fire resistance integrity of the rated assembly.	0 780		

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0 780	Continued From page 7 DOM-E visually verified these deficient findings at the time of discovery. On December 5, 2024, DOM-E stated they did not realize the doors listed above did not positively latch. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 810 SS=E	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) staff 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) Staff 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 staff twice	0 810		

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0 810	Continued From page 8 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 observation, interview, and record review, the licensee failed to provide the required employee training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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: On December 5, 2024, licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. TRAINING The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD-A provided documentation showing training was provided on June 05, 2024, to approximately half of their employees and on October 23, 2024, to approximately half of their	0 810		

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0 810	Continued From page 9 employees. No documentation was provided for trainings in 2023. On December 5, 2024, at 2:00 p.m., LALD-A and DOM-E stated they have a lot of part time employees that only work 3 days a week which makes it difficult to get all the employees to attend the training sessions. DOM-E stated they provided training to the new staff and overnight staff frequently but was not documenting every training. No Further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first	01440		

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01440	Continued From page 10 performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure supervision was completed within 30 calendar days after hire and beginning to provide the delegated to tasks to residents for two of two unlicensed personnel (ULP)-C, ULP-D). 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 the residents). The findings include: On November 3, 2024, at approximately 10:00 a.m., ULP-D was observed administering medication to R2. ULP-C ULP-C was hired on June 6, 2021, and began providing assisted living services. ULP-C's employee record lacked documentation of direct supervision of delegated tasks within 30 days of hire or performing delegated tasks. ULP-D ULP-D was hired on July 17, 2023, and began providing assisted living services.	01440		

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01440	Continued From page 11 ULP-D's employee record lacked documentation of direct supervision of delegated tasks within 30 days of hire or performing delegated tasks. On November 2, 2024, at approximately 11:30 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated all unlicensed personnel administered medications and were provided training and competency validation. On November 3, 2024, at approximately 4:00 p.m., licensed assisted living director (LALD)-A and CNS-B stated the supervision documentation was not in employee records for ULP-C and ULP-D. CNS-B stated they were unaware of the requirement for 30-day supervision by a registered nurse. The licensee's Supervision of Licensed and Unlicensed Personnel policy revised November 15, 2019, indicated direct supervision of unlicensed staff providing delegated nursing tasks or delegated treatments must be performed within 30 days after the person begins work for [licensee]. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
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	01620		

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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
01620	Continued From page 12 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 by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment no more than 90 days after the previous assessment for two of two residents (R2, R5). 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 patterned 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).	01620		

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 _____	12/05/2024

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

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01620	Continued From page 13 The findings include: R2 R2 was admitted on March 6, 2024, and began receiving assisted living services. R2's record included a Service Plan Agreement dated November 22, 2024, indicating R2's services included medication management and administration and assistance with housekeeping and laundry tasks. R2's record included a Comprehensive Assessment/Licensed Services dated May 1, 2024, and a Comprehensive Assessment/Licensed Services dated August 16, 2024, indicating a total of 107 days had passed between assessments. R2's record included a Comprehensive Assessment/Licensed Services dated November 21, 2024, indicating 97 days had passed since the previous assessment dated August 16, 2024. R5 R5 was admitted on August 17, 2022, and began receiving assisted living services. R5's record included a Service Plan agreement dated December 3, 2024, indicating R5's services included dressing and grooming assistance, meal assistance, medication administration, and behavior management. R5's record included a Comprehensive Assessment/Licensed Services dated May 6, 2024, and a Comprehensive Assessment/Licensed Services dated August 12, 2024, indicating 98 days had passed between	01620		

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 _____	12/05/2024

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01620	Continued From page 14 assessments. R5's record included a Comprehensive Assessment/Licensed Services dated November 21, 2024, indicating 98 days had passed since the precious assessment dated August 12, 2024. On December 4, 2024, at approximately 11:00 a.m., clinical nurse supervisor (CNS)-B stated the assessments had been completed past the required 90 days and the issue seemed to occur in a specific unit of the building. The licensee's Assessment of Clients - Initial and Ongoing policy reviewed May 23, 2022, indicated assessments would not exceed 90 days from the date of the last assessment. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman	01640		

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 _____	12/05/2024

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01640	Continued From page 15 for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure revised service plans were authenticated by the resident or resident's representative for one of three residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R4 was admitted on June 17, 2024, and began receiving assisted living services. R4's record included a Service Plan Agreement signed August 12, 2024, indicating R4's services included assistance with dressing and grooming, catheter care, medication management and administration and behavior management. R4's Service Plan agreement, unsigned, dated December 3, 2024, indicated the following services had been changed:	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01640	Continued From page 16 -excessive medications (greater than 10 medications) had been deleted from Service Plan; -dining set-up deleted from Service Plan; -TED hose application and care had been deleted from service plan; -vision aid changed October 24, 2024, from independent to cueing and standby services provided; -nail care changed on October 28, 2024, from an outside provider to being provided by unlicensed staff; -care alert added on November 12, 2024, for ice application and elevation of right lower extremity; -ambulation with physical assistance of one was deleted from service plan; -management of wandering was added to service plan; -catheter care monthly drainage bag change was added to service plan on November 7, 2024, and -skin monitoring was added to service plan on October 28, 2024. R4's service plan changes lacked authentication or signature from R4 or R4's representative. On December 3, 2024, at approximately 3:50 p.m., clinical nurse supervisor (CNS)-B stated they were unaware that service plans required authentication if services change regardless of pricing changes. CNS-B stated they had sent updated service plans for 2025 out for signatures. The licensee's Service Plan Agreement Development and Revision policy revised August 1, 2021, indicated modifications based on the client's needs, preferences, or changes in fees would be signed by the registered nurse (RN) along with the client and/or the client's representative.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01640	Continued From page 17 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		

Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *12/02/24*
Time: 11:00:00
Report: 1039241368

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.

The following orders were issued during this inspection.

4-700 Sanitizing Equipment and Utensils

4-703.11B ***** Priority 1 *****

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

MEMORY CARE KITCHEN - HOT WATER DISHWASHING MACHINE ACHIEVED MAX WATER TEMPERATURE OF 144 DEGREES F AT WARE SURFACE. DISHES WILL BE SENT TO MAIN KITCHEN FOR WAREWASHING. MACHINE SLATED FOR REPLACEMENT IN 2 WEEKS, WILL BE REPAIRED MEANWHILE.

Comply By: 12/02/24

5-200B Plumbing: cross connections

5-203.14 ***** Priority 1 *****

MN Rule 4626.1085A Backflow prevention devices must be installed in accordance with chapter 4714.

ATMOSPHERIC VACUUM BREAKER ASSEMBLY ON KITCHEN AREA MOP SINK FAUCET IS MISSING CAP. COMPLY WITH ABOVE RULE.

Comply By: 12/16/24

6-300 Physical Facility Numbers and Capacities

6-301.11 ***** Priority 2 *****

MN Rule 4626.1440 Provide an adequate supply of hand soap at each handwashing sink or group of 2 adjacent handwashing sinks.

SOAP DISPENSERS NOT FUNCTIONING AT 2 (OF 3) HANDWASHING SINKS IN KITCHEN. COMPLY WITH ABOVE RULE AT ALL TIMES. PIC ADJUSTED DISPENSERS TO FUNCTION.

CORRECTED ON SITE.
Comply By: 12/02/24

4-100 Equipment Construction Materials

4-101.19

MN Rule 4626.0495 Remove non-food-contact surfaces of equipment that are exposed to splash, spillage, or other food soiling, or that require frequent cleaning, that are not constructed of a corrosion-resistant, non-absorbent, and smooth material.

PLASTIC PROTECTIVE FILM STILL ADHERED TO OUTSIDE OF LOW REACH-IN COOLER IN KITCHEN. REMOVE PLASTIC.
Comply By: 12/16/24

Surface and Equipment Sanitizers

Quaternary Ammonium: = 200 PPM at Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: No

Quaternary Ammonium: = 400 PPM at Degrees Fahrenheit
Location: DISPENSER @ 3-COMP SINK
Violation Issued: No

Utensil Surface Temp: = at 177 Degrees Fahrenheit
Location: KITCHEN DISHWASHING MACHINE
Violation Issued: No

Utensil Surface Temp: = at 144 Degrees Fahrenheit
Location: MEMORY CARE SERVICE AREA DISHWASHING MACHINE
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: CHEESE
Temperature: 40 Degrees Fahrenheit - Location: COLD HOLD WALK-IN COOLER
Violation Issued: No

Process/Item: SOUP
Temperature: 37 Degrees Fahrenheit - Location: COLD HOLD WALK-IN COOLER
Violation Issued: No

Process/Item: HB EGG IN SALAD
Temperature: 41 Degrees Fahrenheit - Location: COLD HOLD LOW REACH-IN COOLER
Violation Issued: No

Process/Item: DELI MEAT
Temperature: 41 Degrees Fahrenheit - Location: COLD HOLD IN GRILL PREP COOLER INSERT
Violation Issued: No

Process/Item: BURGER
Temperature: 168 Degrees Fahrenheit - Location: COOKED ON FLAT TOP
Violation Issued: No

Process/Item: FROZEN
Temperature: Degrees Fahrenheit - Location: KITCHEN FREEZERS (WALK-IN, ICE CREAM)
Violation Issued: No

Process/Item: MILK
Temperature: 41 Degrees Fahrenheit - Location: COLD HOLD MEMORY CARE COMBO COOLER
Violation Issued: No

Process/Item: FROZEN
Temperature: Degrees Fahrenheit - Location: MEMORY CARE COMBO FREEZER
Violation Issued: No

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

The inspection was completed with the person in charge and reviewed with MDH nurse evaluator Michelle Winters.

Establishment has a main kitchen on the ground floor and a small service kitchen in the memory care facility. Both kitchens have facilities and equipment meeting commercial standard.

Discussed the following topics with PIC: employee illness policy for establishment, cooling and cold holding and hot holding TCS foods, date marking and disposition, orders on this report.

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 1039241368 of 12/02/24.

Certified Food Protection Manager: Alex Kisch

Certification Number: FM107145 Expires: 04/08/27

Inspection report reviewed with person in charge and emailed.

Signed: _____

Alex Kisch
person-in-charge

Signed: _____

Aron Goodner
Public Health Sanitarian I
Freeman Building
aron.goodner@state.mn.us