Electronically Delivered

December 1, 2023

Licensee
The Towers
1011 Feltl Court
Hopkins, MN 55343

RE: Project Number(s) SL20217015

Dear Licensee:

On November 20, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the August 17, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

PMB

Electronically Delivered

September 21, 2023

Licensee
The Towers
1011 Feltl Court
Hopkins, MN 55343

RE: Project Number(s) SL20217015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 17, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The 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 and enforcement actions 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 the MDH within 15 calendar days of the correction order receipt date.

A state correction 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 reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

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

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: 651-281-9796

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20217	A. BUILDING: _____ B. WING _____	08/17/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER 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: SL20217015 On August 14, 2023, through August 17, 2023, 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 65 active residents receiving services under the Assisted Living 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 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 failed to develop and implement a staffing plan to meet the reasonably foreseeable unscheduled needs of each resident. This had the potential to affect all 65 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, but was not likely to	0 470	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 License Providers. 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	

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0 470	Continued From page 2 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). The findings include: On August 14, 2023, at 10:30 a.m., surveyor observed the daily staffing schedule in the common area by the resident mailboxes. The schedule dated August 14, 2023, indicated there would be one unlicensed personnel (ULP) working from 7:00 a.m. until 12:00 p.m., and one ULP from 3:00 p.m. until 11:00 p.m., as well as one security personnel from 4:00 p.m. to 12:00 a.m., and one security personnel from 12:00 a.m. to 8:00 a.m. The daily staffing schedule also indicated one licensed nurse located in a different licensee's building, attached via a skyway, from 7:30 a.m. to 4:00 p.m., and 12:00 p.m. to 10:00 p.m. The licensee's Criteria for Health Services dated August 1, 2021, was provided to all new residents. The document indicated persons whose needs could be met by the licensee would include residents who require daily help with activities of daily living, necessitating up to four scheduled home care visits per day between the hours of 7:00 a.m. to 11:00 p.m. The document further indicated persons who are unable to have their needs met by the licensee are residents who required unscheduled visits to assist with activities of daily living and require assistance overnight between the hours of 11:00 p.m. to 7:00 a.m. On August 14, 2023, at 10:40 a.m., during entrance conference, licensed assisted living	0 470	"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 surveyors' 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.	

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0 470	Continued From page 3 director (LALD)-A stated the licensee does not provide services to residents from 11:00 p.m. to 7:00 a.m., and as a result they do not staff unlicensed personnel or nurses for the overnight shift. LALD-A stated they have security in the building for emergency response only. LALD-A further stated they do not have a ULP on staff from 12:00 p.m. to 3:00 p.m. LALD-A stated nursing offices are in a separate licensee's building and need to be called to triage emergencies. On August 14, 2023, at 11:40 a.m. clinical nurse supervisor (CNS)-B stated they are very clear with residents and families moving into the licensee's facility that services are not provided from 11:00 p.m. to 7:00 a.m. Each new potential resident received a document called Criteria for Health Services from the [licensee] that stated no services are provided overnight. ULP-E was hired on July 28, 2010, to perform direct care services to the licensee's residents. ULP-E's record included an undated and unsigned Resident Assistant job description and a Security Guard job description signed on February 4, 2011. The licensee's schedule dated July 31 through August 27, 2023, indicated that ULP-E was scheduled to work from 12:00 a.m. to 8:00 a.m., and would be the only staff working from 12:00 a.m. to 7:00 a.m. on July 31, August 1, 2, 3, 6, 7, 8, 9, 14, 15, 16, 17, 20, 21, 22, 23, 24, and 27. ULP-E's record lacked the following training and competency evaluations: - appropriate and safe techniques in personal hygiene and grooming, including:	0 470		

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0 470	Continued From page 4 (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; - standby assistance techniques and how to perform them; -range of motion and positioning; -administering medications or treatments as required; -other registered nurse/professionally delegated tasks; - observation, reporting, and documenting of client status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and - recognizing physical, emotional, cognitive, and developmental needs of the client. ULP-E's employee record lacked documentation of direct supervision of performing a delegated task within 30 days of providing services to verify the work was performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the services. ULP-E's employee records lacked evidence of orientation to assisted living regulations (144G.63, Sub. 2) effective August 1, 2021, for the following: -consumer advocacy services; -review of types of assisted living services the employee will provide and provider's scope of license; -Orientation to each specific resident and services provided; and -initial 8 hours of dementia care training.	0 470		

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0 470	Continued From page 5 On August 15, 2023, at 6:50 a.m., ULP-E stated, "My position as the overnight security is to watch over the two buildings, so I go back and forth between the two buildings via the sky way. Typically, my night starts at 12:00 a.m., and I first check emails, then I do rounds in this building by going up to the top floor, I walk the entire floor and then go down the stairs to the next floor and I do that for every floor. I look to make sure everything is in order, and nothing is wrong, I listen for funny noises, because I have had in the past where a resident was banging on the wall for help, and I had to find where they were banging. Then I go outside and water plants in three different areas, and that takes about thirty minutes, but I keep my phone on me and I respond to any emergencies, making sure that the buildings look nice, and everything is under control. After I do my rounds in this building I go to the other building via the skyway. I am back and forth between the two buildings the entire night. Rounds in the other building take about 30 minutes to do. If there is a resident that has a fall, we are allowed to get the resident up with the help of two people if the nurse gives you permission. First, I will call the nurse if they are one of our residents [receiving services from the licensee] and get permission from them, or get direction to call 911 [if they are housing only residents not receiving services], then the RA [ULP] from the other building will come over and help and the same goes for if they need help over in the other building, they will call me, and I will go over there. We are not allowed to get medications for residents on the overnight unless there is special permission given from the nurses and then I use the keys and I get into the medication box so that the RA from the other building can give the medication. So basically, I just get the RA	0 470		

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0 470	Continued From page 6 into the medication box because I have not had actual medication training." On August 15, 2023, at 12:10 p.m., lead concierge (LC)-F stated she is the manager of the overnight security team and communicated expectations and responsibilities to the team. LC-F stated the night rounds are completed by security staff including watering plants outside, floor rounds in both separately licensed buildings that can last 30 minutes or more, completed at least twice every night. LC-F stated there are no employees in the licensee's building when security is rounding in the separately licensed adjacent building connected by skyway. LC-F stated security rolled the phones to a cell phone and security carried a walkie that pendants would call in case of an emergency. LC-F stated ULP-D, who works the overnight security shift on weekends, is not trained or competency tested as a resident assistant (as ULP-E is). On August 15, 2023, at 1:32 p.m., human resource coordinator (HRC)-H stated, ULP-E had not worked as a resident assistant yet, because the licensee did not provide services between the hours of 11:00 p.m. to 7:00 a.m. On August 16, 2023, at 6:50 a.m., surveyor observed ULP-J enter R7's apartment and explain what they would be doing today. R7 stated, "Well you can just go, I needed help earlier. I awoke at 4:00 a.m., well actually I awoke at 2:00 a.m., and just laid there and watched the clock tick by 2:30, then 3:00, then 3:30, then I finally got up at 4:00 a.m., and after sitting here awhile I was too cold, so I had to do it myself. I just went slow, but I got myself ready for the day, so it is taken care of." R7 went on to explain to surveyor that because there is not staff to provide	0 470		

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0 470	Continued From page 7 cares on the overnight shift, she has been having family spend the night to assist her. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 470		
0 630 SS=D	144G.42 Subd. 6 (b) 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 the required content for one of two residents (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) 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).	0 630		

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0 630	Continued From page 8 The findings include: R5 admitted to the licensee on June 24, 2017, and began receiving assisted living services on August 1, 2021. R5's diagnoses included a traumatic brain injury. R5's record lacked an individual abuse prevention plan which reviewed the resident's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to those residents and other vulnerable adults. On August 16, 2023, at 8:25 a.m., director of nursing (DON)-B stated, "In the assessment [IAPP assessment] you need to click the option to be picked and so it is something that just appears to have been missed on hers, you know how sometimes you think you clicked something and it just wasn't actually clicked, I think that is what happened in this case." The licensee's undated Development of Individual Abuse Prevention Plans policy read the IAPP will include: a. Individualized review or assessment of the resident's susceptibility to be abused by another individual, including other vulnerable adults; b. The resident's risk of abusing other vulnerable adults; c. Specific measures to minimize the risk of abuse to that person and other vulnerable adults; and d. Measure to minimize the risk of self-abuse, if applicable. No further information was provided.	0 630		

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0 630	Continued From page 9 TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms in the immediate vicinity of sleeping rooms and failed to provide smoke alarms that are interconnected so that the	0 780		

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0 780	Continued From page 10 actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and 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, 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 August 15, 2023, at approximately 10:00 a.m., survey staff toured the facility with the Director of Maintenance (DOM)-G. During the facility tour, survey staff observed the following items: In two-bedroom resident unit 901, it was observed that the sleeping rooms that were equipped with smoke alarms were not interconnected with the other smoke alarms in the dwelling unit, so the actuation of one alarm would cause all alarms to operate. During the interview, DOM-G confirmed this deficient condition exists in all one-bedroom, two-bedroom, and three-bedroom units. This deficient condition was visually verified by DOM-G accompanying the tour. It was observed that in three-bedroom units, the required smoke alarms were not installed in the immediate vicinity of sleeping rooms. During the interview, DOM-G confirmed these deficient conditions consistent in all three-bedroom resident units in the building. These deficient	0 780		

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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
0 780	Continued From page 11 conditions were visually verified by DOM-G accompanying the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
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: Based on observation and interview, the licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. 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 August 15, 2023, at approximately 10:00 a.m., survey staff toured the facility with the Director of	0 800		

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	20217	A. BUILDING: _____ B. WING _____	08/17/2023

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0 800	Continued From page 12 Maintenance (DOM)-G. During the facility tour, survey staff observed the following: In the trash chute room door on every floor, it was observed that the door was identified as a 90-minute fire-rated door, but the door jamb installation was not sufficient to meet the rating requirement. There was approximately a three-inch opening between the hollow metal door jamb and gypsum board termination from floor to ceiling. Through the opening, it was also observed that the steel stud wall frame was exposed without any protection, and a layer of gypsum board was missing. In resident unit 509 on the fifth floor, it was observed that door closers on the door had been disabled by removing the closure arm or closure device, and the door did not self-closing. The door closure device is required to make the door close and positively latch to maintain the fire integrity of the resident room and corridor for safety purposes. During the interview, DOM-G stated that the door closers were removed, and spring hinges were installed at the door jamb. DOM-G also stated that this condition was consistent with many doors throughout the facility. In the egress stair by resident unit 443 on the fourth, it was observed that the door frame bears a fire rating label, but the door did not have any fire rating information on it. During the interview, DOM-G confirmed that both the door and door frame need to be rated assembly to maintain the fire barrier integrity of the egress stair. DOM-G also stated that this condition was consistent with most other egress stair doors throughout the facility. In the theater room on the fourth floor, it was	0 800		

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0 800	Continued From page 13 observed that door closers on the door had been disabled by removing the closure arm or closure device, and the door did not self-closing. The door closure device is required to make the door close and positively latch to maintain the fire integrity of the room and corridor for safety. In the corridor by the elevator lobby on the first floor, it was observed that the rated smoke compartment door did not close when released from the hold-open magnet. The doors were detaching from hinges and overlapping at the top. The door is required to close and positively latch when released from the hold-open magnet to maintain fire integrity. This deficient condition was visually verified by DOM-G accompanying the tour. TIME PERIOD FOR CORRECTION: Seven (7) 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.	0 810		

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0 810	Continued From page 14 (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 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 observation, interview, and record review, the licensee failed to develop a fire safety and evacuation plan with the required elements; fire protection procedures necessary for residents, and procedures necessary for resident movement, evacuation, or relocation during a fire or similar emergency with identification of unique or unusual resident needs for the movement or evacuation and failed to conduct required evacuation drills as required by statute. This had the potential to affect all staff, residents, 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	0 810		

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0 810	Continued From page 15 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: An interview and record review were conducted on August 15, 2023, at approximately 1:00 p.m. with the Licensed Assisted Living Director (LALD)-A and the Director of Maintenance (DOM)-G on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. Record review of the available documentation indicated that the fire safety and evacuation plan was not maintained. On the facility tour with the DOM-G, it was observed that the posted fire safety and evacuation plans were not accurate depictions of the egress route and were not matched to the current layout of the facility. In the posted evacuation plans, the elevator lobbies from the second to the ninth floor were enclosed by rated double doors. During the facility tour, it was observed that the rated doors were missing from the second to the sixth floor. During the interview, DOM-G stated that she needed to verify the elevator lobby modification history and update the evacuation plans to match the facility layout based on her finding. This deficient condition was visually verified by DOM-G accompanying the tour. Record review of the available documentation indicated that the fire safety and evacuation plan did not include the facility-specific procedures for resident movement evacuation or relocation during a fire or similar emergency, including the identification of unique or unusual resident needs	0 810		

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0 810	Continued From page 16 for movement or evacuation. The facility plan did include some provisions for the relocation of residents, but it did not specify how to move or evacuate residents or identify the unique and unusual needs of the residents. During the interview, LALD-A stated that they had not been focused on the resident movement or evacuation and that there is no staff available at nighttime except one security personnel to assist residents' evacuation in case of a fire or similar emergency. During the interview, LALD-A confirmed that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated that the facility conducted a fire drill every month, but those conducted drills did not incorporate evacuation procedures to qualify as an evacuation drill. During the interview, LALD-A stated that the provided drill record was a list of accrual fire safety incidents involved with minor stove top food burning incidents in the resident's sleeping unit and the description of how staff responded. But the staff response did not include the drills for evacuation or relocation of residents. LALD-A also stated that the facility has no nighttime staff available to conduct evacuation drills except one facility security person. 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	0 900		

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0 900	Continued From page 17 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. (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 observation and interview, the licensee failed to execute a written contract with the required content for individuals who resided in the second bedroom of a resident's apartment of the licensee's assisted living facility. This practice resulted in a level two violation (a	0 900		

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0 900	Continued From page 18 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: Minnesota Statute 144G.08 subdivision (subd.) 2 dated 2022, indicated an adult is defined as a natural person who has attained the age of 18 years. Minnesota Statute 144G.08 subd. 5 dated 2022, indicated an assisted living contract is defined as the legal agreement between a resident and an assisted living facility for housing and, if applicable, assisted living services. Minnesota Statute 144G.08 subd. 7 dated 2022, indicated an assisted living facility is defined as a facility that provides sleeping accommodations and assisted living services to one or more adults. Minnesota Statute 144G.08 subd. 59 dated 2022, indicated a resident is defined as an adult living in an assisted living facility who has executed an assisted living contract. On August 14, 2023, at 9:00 a.m., during observation of cares and resident interview, R4 stated both of her grown sons are currently living with her in the assisted living apartment. R4 stated she was happy her sons were living with her because they help around the apartment and had even summoned 911 after a fall that occurred in March. R4 stated her younger son sold his	0 900		

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0 900	Continued From page 19 house in February and had been living with her ever since. R4 stated her older son had been living there since May and they did not have a plan to move out. On August 14, 2023, at 11:10 a.m., unlicensed personnel (ULP)-C stated she knew both sons of R4 stay the night most nights, if not all. ULP-C states she had been working in the licensee's facility to cover a primary employee that is on long term paid time off (PTO) for the past few weeks. ULP-C did work in the adjacent separately licensed building and cared for R4's husband. ULP-C stated seeing both of R4's son's daily. R4's uniform assessment tool from June 20, 2023, stated registered nurse (RN) noted that "son lives with her and reminds resident to take her meds." On August 16, 2023, at 12:35 p.m., clinical nurse supervisor (CNS)-B stated she knew that the sons of R4 visited daily and did not know if they had been filling out the form required for overnight guests. CNS-B stated she is not responsible for knowing what family members were signing in daily log, or who filled out the overnight guest form. On August 16, 2023, at 12:55 p.m., licensed assisted living director (LALD)-A stated an assisted living contract was not executed for the individuals who resided in R4's apartment in the assisted living facility. LALD-A stated the licensee was not aware of the family living with resident but would do some investigation and get back to evaluator with follow up. There was no follow up with evaluator by the exit of the survey.	0 900		

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0 900	Continued From page 20 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to a conduct a nursing assessment by a registered nurse (RN) of the physical and cognitive needs for one of four residents (R6) on or before the admission date. 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	01610		

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01610	Continued From page 21 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). R6 admitted for assisted living services on April 13, 2023. R6's diagnosis included embolism and thrombosis of unspecified parts of the aorta, major depressive disorder, generalized anxiety disorder, and mild cognitive impairment of uncertain or unknown etiology. R6's Service Plan Agreement dated July 12, 2023, indicated R6 received assistance with lab arrangements and medication administration. R6's record included a comprehensive assessment signed and dated April 20, 2023, seven days after admission. On August 16, 2023, at 8:20 a.m., clinical nurse supervisor (CNS)-B stated, "There is no way to know what was put in the assessment on each day until it is signed unless IT [information technology] were to dig in and look at each key stroke, so for now you can only go off the date the assessment was locked. I usually lock everything down as soon as I am done so I may have missed that." The licensee's Initial and On-Going Nursing Assessment of Residents Under the Comprehensive Licensed Agency policy dated January 2014, read, "The RN will complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required:	01610		

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01610	Continued From page 22 a. Pre-Admission Assessment b. 14-day assessment: completed up to 14-days after start of services c. Ongoing assessment: completed periodically but no less than every 90 days d. Change in residence condition." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
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.	01620		

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01620	Continued From page 23 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 nursing assessments not to exceed every 90 days for one of four residents (R6), and failed to complete a nursing assessment for a resident after possible change in condition due to hospice service admission (R3). 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: R3 R3 admitted for assisted living services on July 4, 2023. R3's diagnosis included hypertension, heart failure, coronary artery disease, history of deep vein thrombosis, and atrial fibrillation. R3's Service Plan Agreement dated July 3, 2023, indicated R3 received assistance with care coordination, preferred pharmacy, weekly medication set up, and essential services contingency plan. R3's progress notes dated July 27, 2023, at 11:42	01620		

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01620	Continued From page 24 a.m., indicated admission to in home hospice services. R3's record lacked a nursing assessment after admission to hospice services to assess for possible change in condition or added services. R6 R6 admitted for assisted living services on April 13, 2023. R6's diagnosis included embolism and thrombosis of unspecified parts of the aorta, major depressive disorder, generalized anxiety disorder, and mild cognitive impairment of uncertain or unknown etiology. R6's Service Plan Agreement dated July 12, 2023, indicated R6 received assistance with lab arrangements and medication administration. R6's most recent Assessment was dated July 19, 2023, which did not contain a completed in person assessment, and had a nurse's note stating R6 would hang up the phone without speaking to the nurse. R6's record lacked timely 90-day nursing assessments. On August 16, 2023, at 8:12 a.m., clinical nurse supervisor (CNS)-B stated, "I do not have anything further 90-day assessment for [R6] the nurse attempted repeatedly but did not go so well." On August 16, 2023, at 12:10 p.m., CNS-B stated she would not have hospice services listed on the service plans for residents on care coordination services [R3] as they would not be required to	01620		

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01620	Continued From page 25 have that information due to the family managing the medications and extra services provided by hospice. The licensee's Initial and On-Going Nursing Assessment of Residents Under the Comprehensive Licensed Agency policy dated January 2014, read, "The RN will complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: a. Pre-Admission Assessment b. 14-day assessment: completed up to 14-days after start of services c. Ongoing assessment: completed periodically but no less than every 90 days d. Change in residence condition." 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		

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01640	Continued From page 26 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 observation, interview, and record review, the licensee failed to ensure the service plan included a signature or other authentication by the resident and the facility to document agreement on the services to be provided for one of four 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's unsigned service plan dated July 12, 2023, indicated R4 received services including home care services, assistance with dressing for the day, verbal reminders to brush teeth morning and night, make bed, remove trash, assist with changing into pajamas, weekly assistance with shower, making coffee, clean fridge, weekly medication set up, and daily medication administration.	01640		

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01640	Continued From page 27 On August 15, 2023, at 8:44 a.m., surveyor observed unlicensed personnel (ULP)-C complete R4's medication administration and reminder to brush teeth. R4's Progress Note dated July 11, 2023, at 3:43 p.m., indicated LPN spoke with R4's son and daughter and they planned for R4 to receive morning and evening cares and twice daily medication administration to start on July 13, 2023. R4's Service Plan dated July 12, 2023, lacked a signature or other authentication by the resident or resident's representative or by the facility, documenting agreement on the services to be provided. On August 16, 2023, at 12:10 p.m., clinical nursing supervisor (CNS)-B stated licensee had not received a signature for R4's updated service plan completed on July 12, 2023. CNS-B stated another nurse had been calling the son to get a signature, but they had not received that yet. CNS-B stated to her knowledge the nurse attempting to obtain the signature had not been directly to the apartment to get the signature. CNS-B stated there was no record of any attempts to get a signature of the service plan. The licensee's service plan policy dated August 1, 2021, indicated, all assisted living residents will have an up-to-date service plan identifying services to be provided based on the assessment by the RN and/or other licensed health professional. Service plans and any revisions to services plans will have a signature or other authentication by the facility and by the resident. Other authentication could be emailed confirmation accepting terms of a service	01640		

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01640	Continued From page 28 agreement or other method deemed appropriate by the assisted living. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01650 SS=D	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.	01650		

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01650	Continued From page 29 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for one of four residents (R3). 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: R3's service plan signed July 3, 2023, indicated R3 received services including care coordination, preferred pharmacy services, and weekly medication set up. R3's service plan lacked inclusion of hospice services. R3's progress notes from July 27, 2023, at 11:42 a.m., indicate R3 signed on to in home hospice services. R3's hospice plan of care dated July 27, 2023, indicated R3 received the following hospice services: one visit every seven to ten days registered nurse (RN), twice monthly medical social worker (MSW), and one visit every seven to ten days home health aide (HHA). On August 16, 2023, at 9:00 a.m., surveyor observed R3 in her room taking her medications that were set up by hospice services. Resident	01650		

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01650	Continued From page 30 stated she was admitted to hospice services a few weeks ago due to a diagnosis of stomach cancer. On August 16, 2023, at 12:10 p.m., clinical nursing supervisor (CNS)-B stated licensee had not completed service plan updates after hospice admissions if residents had only care coordination from licensee, and they were not aware they should. CNS-B further stated they do not assume a hospice admission would be a change in condition or need an assessment to observe for changes for service plan adjustments. CNS-B stated with R3 having care coordination oversight only by the licensee they would not be responsible to add hospice services to the service plan. The licensee's service plan policy dated August 1, 2021, indicated, all assisted living residents will have an up-to-date service plan identifying services to be provided based on the assessment by the RN and/or other licensed health professional. Service plans and any revisions to services plans will have a signature or other authentication by the facility and by the resident. Other authentication could be emailed confirmation accepting terms of a service agreement or other method deemed appropriate by the assisted living. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan	01730		

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01730	Continued From page 31 (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing	01730		

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01730	Continued From page 32 medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individualized medication management record with the required content for one of four 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 to licensee's care on January 8, 2020. R4's unsigned Service Plan Agreement dated July 20, 2023, indicated R4 received the services of a weekly bath or shower and morning and evening medication administration. R4's Medication/Treatment Sheet dated August 2023, indicated R4 received medications administered by unlicensed personnel (ULP) for August 1, 2023, through August 14, 2023. R4's medication management plan lacked updating since January 8, 2020, which listed R4 took her own medications at that time. R4's latest Uniform Assessment tool from June 20, 2023, indicated daughter set up medication in a weekly pill box and resident took medication	01730		

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01730	Continued From page 33 with reminders from her son that lives with her. R4's record lacked an updated medication management plan. On August 16, 2023, at 12:10 p.m., clinical nurse supervisor (CNS)-B stated licensee does not automatically updated the medication management plan annually. CNS-B stated licensee developed each resident's medication management plan based on the most recent assessment. CNS-B stated medication management plans are done on admission for residents who are getting care coordination services and taking their own medications, once medication administration services go to the licensee, RN does not need to complete the full medication management plan assessment because the licensee's employees have the proper medication training. The licensee's Individualized Medication, Treatment and Therapy Management Plan policy dated May 24, 2022, indicated: 1. RN developed a medication management plan for each resident receiving medication management services. The medication management plan will include: a. Statement of the medication management services provided to the resident b. Description of medication storage based upon the resident's needs, preferences, risk of diversion, and in keeping with the manufacturer's instructions c. Documentation of specific resident instructions relating to the administration of medications d. Identification of persons responsible for monitoring and ensuring timely refills of medications	01730		

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01730	Continued From page 34 e. Identification of medication management tasks that may be delegated to an unlicensed person. f. Procedure for notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services g. Resident-Specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medications used to prevent possible complications or adverse reactions. 2. Medication, treatment, and therapy management plans will be current and updated when there are changes. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.	01760		

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01760	Continued From page 35 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered appropriately for one of four residents (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 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: R5's Service Plan Agreement signed February 24, 2023, indicated R5 received assistance with medication administration and a 15-minute nurse visit every 14 days for an injection. R5's Medication/Treatment Sheet dated August 1, 2023, through August 31, 2023, included one tablet of Fexofenadine hydrochloride 180 milligrams (mg), aspirin 81 mg, gabapentin 100 mg, levothyroxine sodium 100micrograms (mcg), and lisinopril 2.5 mg. On August 15, 2023, at 7:21 a.m., surveyor observed unlicensed personnel (ULP)-C enter R5's apartment and explain they were there for medication administration. ULP-C obtained the tackle box containing R5's medications and proceeded to punch out medications from a medication card for each of the above medications without looking at the	01760		

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01760	Continued From page 36 Medication/Treatment Sheet. ULP-C administered the medications to R5, and after administration ULP-C retrieved a folded-up Medication/Treatment Sheet from the medication tackle box and unfolded the sheet and signed off each medication given. On August 16, 2023, at 12:14 p.m., clinical nurse supervisor (CNS)-B stated, "the expectation is to pull out the MAR [Medication/Treatment Sheet] to check. To do the rights and the three checks. If you are referencing the aide you watched yesterday, I know she said she was really nervous so that is probably what happened." The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy, dated August 1, 2021, read, "Medications, treatment and therapy always need to be administered according to the "6 Rights" a. Right person b. Right medication, treatment or therapy c. Right time d. Right route (by mouth, eye drops, to the skin, etc.) e. Right dose (how many milligrams, drops, etc.) f. Right chart/record to documents that the medication, treatment and therapy was taken." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		