Electronically Delivered

February 17, 2023

Licensee
Seven Hills Senior Living
733 Selby Avenue
Saint Paul, MN 55104

RE: Project Number(s) SL34963015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on January 25, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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 evaluation of your facility**.

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for

reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

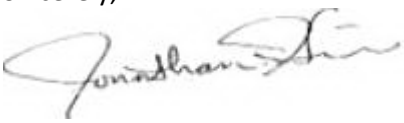
Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

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 this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34963	A. BUILDING: _____ B. WING _____	01/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN HILLS SENIOR LIVING	733 SELBY AVENUE SAINT PAUL, MN 55104

(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 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: SL34963015-0 On January 23, 2023 through January 25, 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 seventy-two (72) residents, 38 received services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living with Dementia Care facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 580 SS=F	144G.42 Subd. 2 Quality management	0 580		

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0 580	Continued From page 1 The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all 72 current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 23, 2023, at 10:00 a.m., during the entrance conference, a request was made to review documentation of the licensee's quality management activities.	0 580		

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0 580	Continued From page 2 On January 23, 2023, at 11:30 a.m., director of nursing (DON)-B provided a binder which included Quarterly Staff Meeting notes, dated November 23, 2022. The meeting notes included a list of quality management activities the licensee was reviewing which included Covid concerns, medication disposal, and staffing concerns. The meeting notes lacked documentation of interventions to determine if changes in services provided or other procedures need to be made to ensure safe and competent services to licensee residents. On January 24, 2023, at 2:20 p.m., licensed assisted living director (LALD)-C confirmed the administrative staff meet weekly to discuss licensee concerns, but verified no documentation of goals or interventions was included in the meeting notes. The licensee's Quality Management Plan policy, dated August 1, 2021, confirmed "the Assisted Living Director will develop a continuous quality improvement and management program to maintain the agency's continuous performance improvement efforts, consistent with current professional standards and the highest services for residents." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with	0 780		

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0 780	Continued From page 3 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 a working smoke alarm inside the sleeping room of resident apartment unit 208. This has the potential to directly affect the resident in unit 208. 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	0 780		

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0 780	Continued From page 4 situation has occurred only occasionally). The findings include: On January 25, 2023, approximately from 11:15 a.m. to 3:30 p.m., survey staff toured the facility with the director of maintenance (DM)-E and the licensed assisted living director (LALD)-A. At approximately 1:15 p.m., the LALD-A left the tour. During the tour, survey staff observed inside apartment unit 208, the sleeping room was missing the required smoke alarm. The finding was evident when survey staff observed the wall-mounted housing of the smoke alarm had exposed wire. The DM-E explained that the smoking alarm in the sleeping had failed and a battery smoke alarm was provided as a temporary solution inside the sleeping room while they are waiting for the new compatible hardwired smoke alarm to be delivered for replacement. The DM-E stated they have reviewed the temporary solution with the local fire department for acceptance. On January 25, 2023, at approximately 4:20 p.m., during the exit interview, the LALD-A and the DM-E acknowledged the above finding. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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	0 800		

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0 800	Continued From page 5 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 of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of 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 January 25, 2023, approximately from 11:15 a.m. to 3:20 p.m., survey staff toured the facility with the director of maintenance (DM)-E and the licensed assisted living director (LALD)-A. At approximately 1:15 p.m., the LALD-A left the tour. During the tour, survey staff observed the following: 1. The fire alarm panels indicated a trouble alarm in resident unit 426. The DM-E stated the smoke detectors (with alarm capability) in unit 426 appeared to be working properly with green blinking lights but the fire alarm panel still showed a trouble alarm. The DM-E verified the finding as he also stated that he will have the fire alarm	0 800		

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0 800	Continued From page 6	0 800		

contractor in the next day to troubleshoot the alarm panel.
2. The licensee lacked a record of the annual fire alarm detection tests and inspections. Survey staff requested but no record was available or provided for review.
3. In resident apartment unit #408, the unit in its entirety was uncleaned. Survey staff observed the floor was full of debris and trash throughout the unit, the shower floor/wall was dirty, the vanity counter was stained with dirty substances, and the kitchen sink and counters had an excessive build-up of food stains and other substances. The LALD-A and the DM-E confirmed the findings.
4. In resident rooms 221 and 301A, the toilet bowls were stained and soiled and needed to be cleaned. The DM-E verified the findings.
5. The trash room door on the 4th floor was missing a door self-closing hardware preventing the door from self-closing to maintain the fire rating of the trash room.
6. The trash room door in the basement parking garage was missing a door self-closing hardware preventing the door from self-close and positive latched as required. In addition, the door handle was damaged and missing from the door on the inside.
7. The filters for the "PTAC" wall-mounted units inside the resident apartment units were filled with thick dusts (units 12, 14, 301A, 301D, 301B, 301A, etc). The DM-E confirmed the findings and agreed to change all "PTAC" unit filters.
8. The filters for the "Magic Pak" heating cooling units in resident rooms 109, 112, and 222 were dirty and needed to be replaced. The DM-E confirmed the findings.
9. The 3rd-floor laundry room across from room 306 was extremely warm when the survey staff and the DM-E entered the room. Upon further

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0 800	Continued From page 7 investigation, the dryer exhaust duct was disconnected from the dryer and hot air from the dryer discharged into the room while the dryer was in use. Survey staff observed excessive lint in the room and both dryers felt fairly hot to the touch. The DM-E confirmed the find as he stopped one of the dryers in operation and locked up the room from resident access until service is called for investigation and repair. 10. An extension cord was used in unit 301D (serving heating pad) and 210 (serving with the reclining chair) that posed a potential electrical fire hazard from overloading the electrical circuits. The DM-E confirmed the findings. 11. Electrical panels inside each memory care resident unit were readily accessible to the residents and posed safety concerns from turning the switches in the off position. 12. Cleaning chemicals and a cutting knife were observed in memory care resident unit 15. The LALD-A explained that the resident was bed-bound. The nurse relocated the knife and removed the cleaning chemicals from potential access. 13. The chemical soap dispenser connected to the faucet of the mop sink located inside the commercial kitchen area was not protected with the proper pressure bleeding device, creating a risk of backflow of chemicals into the potable water supply. On January 25, 2023, at approximately 4:20 p.m., during the exit interview, the LALD-A and the DM-E acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		

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0 810	Continued From page 8	0 810		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees 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, record review, and	0 810		

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0 810	Continued From page 9 interview, the licensee failed to provide the complete content of the fire safety and evacuation plan, the correct frequency of employee evacuation drills, and the minimum required training on fire safety and evacuation. This has the potential to directly affect the safety of all residents receiving services, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 25, 2023, at approximately 3:30 p.m., survey staff received the facility fire safety and evacuation plan and related documentation for review from the licensed assisted living director (LALD)-A. At approximately 4:20 p.m., document review and interview with the LALD-A and the director of maintenance (DM)-E indicated the following findings: 1. The evacuation floor layout lacked a location and number of sleeping rooms. During the interview, the LALD-A verified that the fire safety and evacuation plan for the facility lacked these provisions. 2. The fire safety and evacuation plan lacked identification of unique or unusual resident needs for movement or evacuation under procedures for resident movement, evacuation, or relocation during a fire or similar emergency. Unique resident needs during emergency movement or an evacuation may be residents who have mobility limitations, bedbound, cognitive	0 810		

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0 810	Continued From page 10 impairment, visual/hearing impairment, or any residents needing assistance during an evacuation must be addressed in the fire safety and evacuation plan documentation. During the interview, the LALD-A verified that the fire safety and evacuation plan for the facility lacked these provisions. 3. The fire safety and evacuation plan lacked fire protection procedures for residents. 4. The licensee lacked a record of employee training specifically on the fire safety and evacuation plan. Survey staff explained to the LALD-A and the DM-E that the minimum required employee training is twice a year after new hire orientation for fire safety and evacuation. The policy documentation provided by the LALD-A during the interview showed orientation training annually. In addition, no record of documented dates when training was provided was available for review to substantiate training for the year 2022. 5. The licensee lacked a record to show that required annual resident training was available that can self-assist in their own evacuation on proper actions to take in the event of a fire including movement, evacuation, or relocation. No record was available or provided for review. 6. The drill records showed an insufficient number of employee fire evacuation drills performed to date. Drill records received for review were based on quarterly frequency as documented in the training policy (undated). Drill records provided for review to date were 9/23/2022, 9/16/2022, and 6/13/2022. Survey staff explained to the LALD-A and the DM-E that the minimum required frequency of two fire evacuation drills for employees is twice per year per shift with at least one evacuation every other month.	0 810		

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0 810	Continued From page 11 On January 25, 2023, at approximately 4:20 p.m., during the exit interview, the LALD-A and the DM-E acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 810		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for resident health, safety, or personal property. This had the potential to affect all residents. This practice resulted in a level one 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).	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34963	A. BUILDING: _____ B. WING _____	01/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN HILLS SENIOR LIVING	733 SELBY AVENUE SAINT PAUL, MN 55104

(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
0 970	Continued From page 12 The findings include: On January 23, 2023, at approximately 1:00 p.m., the surveyor requested a copy of the facility's assisted living contract. The licensee's Master Assisted Living Resident Agreement included a section for Indemnification that read, "Resident will indemnify and hold harmless Facility, its employees and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury, or damage to property, arising from or out of the use by Resident...the Apartment or any part of the Facility..." On January 24, 2023, at 2:20 p.m. Regional Director (RD)-G confirmed the licensee's assisted living contract included the above content, and stated the same contract was utilized for all residents at the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services;	01470		

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01470	Continued From page 13 (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or	01470		

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01470	Continued From page 14 (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-C) received orientation to assisted living facility licensing requirements before providing services to licensee 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C lacked documentation of training on the Assisted Living statutes 144G. ULP-C had a hire date of March 16, 2020. On January 24, 2023, at 8:00 a.m., ULP-C was observed to administer medications to licensee residents on the memory care unit. ULP-C's employee record lacked evidence to indicate the employee received orientation to include: - an overview of Assisted Living statutes 144G.	01470		

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01470	Continued From page 15 On January 24, 2023, at 2:20 p.m., licensed assisted living director (LALD)-C confirmed orientation to the assisted living requirements and regulations had not been completed by ULP-C. The licensee's Assisted Living with Memory Care Orientation-All Staff policy dated July 28, 2021, indicated "all assisted living employees must complete an orientation to assisted living facility licensing requirements and regulations before providing services to residents." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01470		
01540 SS=F	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;	01540		

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01540	Continued From page 16 This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to ensure employees received the required hours of dementia care training for one of two employees (registered nurse (RN)-B) with training records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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: RN-B was hired on April 5, 2021, to provide direct care services to the licensee's residents and supervisory services to the licensee's staff. The employment record of RN-B lacked documentation of the required eight hours of initial dementia care training within 80 working hours of the employment start date. On January 23, 2023, at approximately 3:30 p.m., licensed assisted living director (LALD)-A confirmed RN-B had not completed the required initial dementia training. The licensee's Assisted Living with Memory Care Dementia Training policy, dated August 1, 2021, indicated direct care employees must have completed eight hours of initial dementia training within 80 hours of employment. No further information provided.	01540		

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01540	Continued From page 17 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on the document review and interview, the licensee failed to develop a hazard vulnerability or safety risk assessment plan to identify hazard vulnerabilities and mitigations on and around the property to protect memory care residents from harm. This has the potential to directly affect staff, visitors, and all memory care residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients).	02040		

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02040	Continued From page 18 The findings include: On January 25, 2023, at approximately 4:00 p.m., a document review indicated the license failed to develop the site-specific safety risk assessment and mitigation plan on and around the property to protect the memory care residents from harm. This finding was evident as there was no site-specific plan documentation provided for review and was confirmed during the interview with the director of maintenance (DM)-E and the licensed assisted living director (LALD)-A at 4:20 p.m. On January 25, 2023, at approximately 4:30 p.m., during the exit interview survey staff discussed the findings and explained to the LALD-A and the DM-E that all potential safety risks or vulnerabilities on and around the property must be identified, assessed, and mitigated and be documented in the plan documentation to protect the memory care residents from harm. The LALD-A acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's	02110		

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02110	Continued From page 19 values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living facility with dementia care provided the required policies and procedures to five of five residents (R2, R3, R4, R5, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or	02110		

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02110	Continued From page 20 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 January 24, 2023, the records of R2, R3, R4, R5, and R6 lacked documentation for receipt of the following required policies and procedures to be provided at the time of resident move-in to the facility: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and	02110		

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02110	Continued From page 21 (10) safekeeping of residents' possessions. On January 24, 2023, at 2:20 p.m. Regional Director (RD)-G confirmed the licensee failed to provide the required policies and procedures to residents on move-in. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as	02170		

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02170	Continued From page 22 entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written individualized activity plan for four of five residents (R2, R3, R4, and R5) who resided in the assisted living facility with dementia care. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). The findings include: The license had a current assisted living with dementia care license. R2 had diagnoses to include hypertension. R3 had diagnoses to include diabetes R4 had diagnoses to include a cerebral vascular	02170		

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02170	Continued From page 23 accident (CVA). R5 had diagnoses to include Frontotemporal Dementia with Aphasia [a form of dementia which results from degeneration of the frontal or temporal lobes of the brain which involves speech and language]. R2, R3, R4, and R5 records lacked evidence that the residents had been evaluated for activities according to the licensing rules of the facility, to include the following: - past and current interests - current abilities and skills - emotional and social needs and patterns - physical abilities and limitations - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions In addition, R2, R3, R4, and R5 records lacked the development of an individualized activity plan. On, January 24, 2023, at 12:30 p.m., the Life Enrichment Director (LED)-F confirmed an activity evaluation and individualized activity plan had not been completed for R2, R3, R4, and R5 as required. LED-F stated she developed a new form and is in the process of implementing the evaluation and plan for all licensee residents. The licensee's Description of Life Enrichment Programs and how Activities are Implemented in ALFDC [assisted living with dementia care] policy dated October 26, 2021, verified "each resident receiving assisted living services will be evaluated for activities." The policy included the above required evaluation topics. The policy included "an individualized activity plan will be developed	02170		

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02170	Continued From page 24 for those receiving assisted living services based on their activity evaluation." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		

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

Type: Full
Date: *01/24/23*
Time: 12:40:19
Report: 1021231017

Food and Beverage Establishment Inspection Report

Location:
Seven Hills Senior Living
733 Selby Avenue
St Paul, MN55104
Ramsey County, 62

Establishment Info:
ID #: 0038442
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6512222003
ID #:

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

No NEW orders were issued during this inspection.

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

THE FOOD SERVICE AT THIS ESTABLISHMENT IS DONE THROUGH A THIRD PARTY COMPANY. UNIDINE IS CONTRACTED BY SEVEN HILLS SENIOR LIVING. KITCHEN STAFF ARE NOT EMPLOYED BY THE SENIOR LIVING FACILITY.

THE MINNESOTA DEPARTMENT OF HEALTH (MDH) FOOD POOLS AND LODGING SECTION (FPLS) PROVIDED THE FACILITY WITH A LICENSE APPLICATION AND FPLS IS TAKING OVER THE LICENSING AND INSPECTION OF THIS FACILITY.

PLEASE CONTACT FPLS IF ANYTHING CHANGES WITH THE LICENSING OF THIS FACILITY.

Food and Beverage Establishment Inspection 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 1021231017 of 01/24/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
JOHNNIE JOHNSON
CHEF MANAGER

Signed:_____
Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us