Electronically Delivered

January 2, 2025

Licensee
Alex Assisted Living LLC
90 East Lake Cowdry Road Northwest
Alexandria, MN 56308

RE: Project Number(s) SL30718016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 20, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30718	A. BUILDING: _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEX ASSISTED LIVING LLC	90 EAST LAKE COWDRY ROAD NW ALEXANDRIA, MN 56308

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30718016-0 On November 18, 2024, through November 20, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 24 residents; 24 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 1 (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 develop an individual abuse prevention plan (IAPP) with the required content for three of three residents (R2, R3, and R4). 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). The findings include: R2 R2 was admitted to the licensee on September 12, 2022. R2's IAPP dated March 12, 2024, indicated R2 was at risk to be abused and not at risk of abusing others but did not include: - statements of specific measures to be taken to	0 630		

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0 630	Continued From page 2 minimize the risk of abuse to that person and other vulnerable adults. R3 R3 was admitted to the licensee on January 19, 2021. R3's IAPP dated August 22, 2024, indicated R3 was at risk to be abused and not at risk of abusing others but did not include: - statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. R4 R4 was admitted to the licensee on March 8, 2023. R4's IAPP dated August 22, 2024, indicated R4 was not at risk to be abused and not at risk of abusing others but did not include: -statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On November 19, 2024, at 1:00 p.m., Clinical Nurse Supervisor (CNS)-B stated, "The IAPP's were missing the interventions to prevent abuse and this would be the case for all of the residents so I am updating them all now." The licensee's 6.05 Individual Abuse Prevention Plan policy dated August 1, 2021, indicated the plan will 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	0 630		

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0 630	Continued From page 3 to minimize the risk of abuse to that person and other vulnerable adults. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 660 SS=E	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing and screening for one of three employees (unlicensed personnel (ULP)-G, In addition, the licensee failed to ensure a negative TB blood test result prior to direct	0 660		

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0 660	Continued From page 4 contact with residents for one of three employees ULP-C. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: The licensee's TB risk assessment form dated November 18, 2024, indicated the facility was at a low risk for TB transmission. ULP-C ULP-C was hired to provide direct care services to the licensee's residents on July 29, 2024. ULP-C's record included a Baseline TB Screening Tool for Health Care Personnel form dated July 29, 2024. ULP-C's record contained evidence of a single Quantiferon Gold blood test with negative result on August 22, 2024, however, employee's training schedule indicated there was direct resident contact beginning on August 13, 2024. ULP-C's employee timesheet dated August 4, 2024, through August 17, 2024, indicated ULP-C worked on August 13, 2024, through August 17, 2024. ULP-C's record lacked the following information: - testing for the presence of infection with	0 660		

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0 660	Continued From page 5 Mycobacterium tuberculosis by administering either a single TB blood test or a two-step tuberculin skin test (TST) prior to direct resident contact. ULP-G ULP-G had a hire date of July 31, 2019, under the home care license and began providing assisted living services on August 1, 2021. ULP-G's record included a Baseline TB Screening Tool for Health Care Workers (HCW) form dated August 5, 2019. ULP-G's record contained evidence of completion of the first step in the two-step TST on August 7, 2019. ULP-G's record lacked the following information: - completion of the second step in the two step TST. On November 20, 2024, at 1:30 p.m., clinical nurse supervisor (CNS)-B stated that ULP-C was in the facility and completed competency testing with [CNS-B] on August 12, 2024, and then started working on the floor right away. CNS-B agreed the test results were dated August 22, 2024, which was after ULP-C began having direct contact with residents, reflected by ULP-C training schedule calendar. On November 20, 2024, at 2:00 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated ULP-C's time sheet dated August 4, 2024, through August 17, 2024, indicated ULP-C had some resident contact and worked on the floor prior to the negative TB test result.	0 660		

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0 660	Continued From page 6 On November 20, 2024, at 5:15 p.m., LALD/LPN-A stated ULP-G only had a 1-step TST due to Tuberculin shortage at the time she was hired. On November 21, 2024, at 8:30 a.m., LALD/LPN-A stated "I did not find [ULP-G's] form where the test was re-started. The process was either completed and documentation was misplaced, or it was missed." The Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, indicated an employee may begin working with patients [residents] after a negative TB symptom screen and a negative Interferon Gamma Release Assay (IGRA) or TST (i.e., first step) dated within 90 days before hire. The Minnesota Department of Health's Assisted Living Resources and Frequently Asked Questions (FAQs) dated October 15, 2024, indicated baseline TB screening includes: - assessing for current symptoms of active TB disease; - assessing TB history; and - testing for the presence of Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or single TB blood test. The licensee's 8.16 Tuberculosis Screening policy dated August 1, 2021, indicated Staff whose essential job functions require work within the same air space of home care clients will be screened and tested for tuberculosis prior to the staff being exposed to clients. Baseline (upon hire) screening will be completed, but serial (annual) screening will only be required with increased occupational risk or exposure. Screening will be conducted as follows:	0 660		

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0 660	Continued From page 7 1. New staff will be screened for active signs of TB using the Baseline TB Screening Tool for HCWs; 2. New staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs; 3. No staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is received and documented; 4. Staff TB screening results will be kept in each employee medical file; 5. Staff should be screened for signs and symptoms on an annual basis. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or	0 810		

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0 810	Continued From page 8 evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice 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 the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 810		

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0 810	Continued From page 9 On November 19, 2024, at 9:47 a.m., licensed assisted living/licensed practical nurse (LALD/LPN)-A director of maintenance (DOM)-D, accounting director (AD)-F provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The FSEP (fire safety and evacuation plan) included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) was very basic. The provided FSEP was from a third-party provider and had not been updated to meet the specific layout of this facility and provide complete actions for employees to take in the event of a fire or similar emergency. LALD/LPN-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01470 SS=E	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	01470		

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01470	Continued From page 10 person; (3) handling of emergencies and use of emergency services; (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 staff member 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	01470		

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01470	Continued From page 11 age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received orientation to assisted living licensing requirements and regulations prior to providing services for two of four employees (licensed practical nurse (LPN)-E and unlicensed personnel (ULP)-G). 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: LPN-E LPN-E had a hire date of February 14, 2020, under the home care license and began providing assisted living services on August 1, 2021.	01470		

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01470	Continued From page 12 On November 20, 2024, at 8:00 a.m., surveyor observed LPN-E administering medications to the licensee's residents. ULP-G ULP-G had a hire date of July 31, 2019, under the home care license and began providing assisted living services on August 1, 2021. LPN-E and ULP-G's employee record lacked documented evidence of the following orientation topic: - Review of types of Assisted Living services the employee will provide and provider's scope of license. On November 21, 2024, at 8:30 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated that LPN-E and ULP-G did not have evidence of the review of types of assisted living services the employee will provide and provider's scope of license because "it was missed." The licensee's 4.18 Employee General Orientation policy dated August 1, 2021, indicated the following: - The supervisor is responsible to ensure that proper orientation procedures and documentation are completed; - General orientation will be scheduled to begin immediately upon hire of all new employees and be completed within the specified time frame; - Employees should not perform job duties before the completion of orientation to the job including general and safety orientation; and - An orientation checklist will be completed by the employee and trainer, signed by each person, and will be filed in the employee's record.	01470		

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01470	Continued From page 13 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and	01500		

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01500	Continued From page 14 (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for three of three employees (licensed practical nurse (LPN)-E, unlicensed personnel (ULP)-G, and ULP-H). 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	01500		

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01500	Continued From page 15 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: LPN-E LPN-E had a hire date of February 14, 2020, under the home care license and began providing assisted living services on August 1, 2021. On November 20, 2024, at 8:00 a.m., surveyor observed LPN-E administering medications to the licensee's residents. ULP-G ULP-G had a hire date of July 31, 2019, under the home care license and began providing assisted living services on August 1, 2021. ULP-H ULP-H had a hire date of July 10, 2015, under the home care license and began providing assisted living services on August 1, 2021. On November 20, 2024, at 8:00 a.m., surveyor observed ULP-H administering medications to the licensee's residents. LPN-E, ULP-G, and ULP-H's record lacked documentation of annual training to include: - Review of provider's policies and procedures. On November 21, 2024, at 8:30 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the staff review select policies and procedures at each staff meeting and they are aware of where the policy and procedure binder is located. LALD/LPN-A stated they thought this was meeting the statute	01500		

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01500	Continued From page 16 requirement. The licensee's 5.06 Annual Required Staff Training policy dated August 1, 2021, indicated the following training elements MUST be included every 12 months to all staff who performs direct care services: 1. Training on reporting of maltreatment of vulnerable adults under section 626.557; 2. Review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; 3. Review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; 4. Effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; 5. Review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and 6. Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		

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01730	Continued From page 17	01730		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (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.	01730		

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01730	Continued From page 18 (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to develop and maintain a current individualized medication management record to include all required content for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On November 20, 2024, at 9:00 a.m., licensed practical nurse (LPN)-E administered medications to R2. R2 was admitted on September 12, 2022. R2's signed service plan dated June 28, 2024, indicated R2 received services to include medication administration per physician order. R2's signed provider orders dated May 28, 2024, included Desitin Cream 13% (skin barrier) and Vicks VapoRub External Ointment 4.7-1.2-2.6% (topical decongestant)- apply topically to specified area unsupervised self-administration.	01730		

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01730	Continued From page 19 R2's individualized medication management plan dated March 12, 2024, indicated medication management services will be provided by facility staff only. R2's uniform assessment tool dated August 29, 2024, indicated R2 has been deemed unable to safely self-administer medications. On November 19, 2024, at 2:30 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated R2's assessments are incorrect, and the orders are correct; R2 can self-administer these meds. On November 19, 2024, at 2:32 p.m., clinical nurse supervisor (CNS)-B stated R2's assessments are on the schedule to be updated next week. The licensee's 7.03 Medication Management Individualized Plan dated August 1, 2021, indicated: 1. [licensee] will develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: a. A statement describing the medication management services that will be provided; b. A description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; c. Documentation of specific resident instructions relating to the administration of medications; d. Identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; e. Identification of medication management tasks	01730		

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01730	Continued From page 20 that may be delegated to unlicensed personnel; f. Procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and g. 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. 2. The medication management record will be current and updated when there are any 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. This MN Requirement is not met as evidenced	01760		

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01760	Continued From page 21 by: Based on observation, interview, and record review, the licensee failed to ensure medications were transcribed as prescribed for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On November 20, 2024, at 9:00 a.m., surveyor observed licensed practical nurse (LPN)-E administer R2's scheduled medications. R2 was admitted on September 12, 2022. R2's diagnoses included chronic obstructive pulmonary disease (COPD), gastroesophageal reflux disease (GERD), cerebrovascular disease, essential hypertension, chronic pain, nonspecific abnormal finding of lung field, and history of COVID-19. R2's signed service plan dated June 28, 2024, indicated R2 received medication administration per physician order. R2's signed provider orders dated May 28, 2024, included orders for Mucinex oral tablet Extended Release (ER) 12- Hour 600 milligrams (mg): give 1 tablet by mouth two times a day for cough and Mucinex ER 12 hour 600 mg: give 1 tablet by	01760		

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01760	Continued From page 22 mouth as needed (PRN) for congestion twice daily. R2's medication administration record (MAR) dated November 1, 2024, through November 30, 2024, lacked the Mucinex ER PRN order. On November 19, 2024, at 2:30 p.m., licensed assisted living director (LALD)/LPN-A stated the provider made a short-term change in the scheduled dose of Mucinex ER for two weeks which put the PRN order on hold. During transcription of instructions to return to the original order, the Mucinex ER PRN order was missed. The licensee's 7.20 Medication & Treatment Orders policy dated August 1, 2021, indicated the registered nurse (RN)/LPN is responsible for assuring that: - current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the residents' records; - communicated to the resident or responsible party; - educate resident or responsible party on all medication and treatment orders; and - changes in orders are addressed in the resident's service plan and are communicated to the other staff. A residents MAR and treatment administration record (TAR) will be audited regularly by licensed nurse or designee for documentation compliance. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

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01820	Continued From page 23	01820		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of three residents (R2). 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 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 occurs only occasionally). The findings include: On November 20, 2024, at 9:00 a.m., surveyor observed licensed practical nurse (LPN)-E administer R2's scheduled medications. R2 was admitted on September 12, 2022. R2's diagnoses included chronic obstructive pulmonary disease (COPD), gastroesophageal reflux disease (GERD), cerebrovascular disease, essential hypertension, chronic pain, nonspecific abnormal finding of lung field, and history of COVID-19.	01820		

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01820	Continued From page 24 R2's signed service plan dated June 28, 2024, indicated R2 received medication administration per physician order. R2's record lacked authenticated current prescription orders for Doxycycline and Prednisone. On November 19, 2024, at 2:30 p.m., licensed assisted living director/ licensed practical nurse (LALD/LPN)-A stated R2's record contained an after-visit summary indicating new orders for Doxycycline and Prednisone however, signed provider orders were not obtained from pharmacy until today. The licensee's 7.20 Medication & Treatment Orders policy dated August 1, 2021, indicated the registered nurse (RN)/LPN is responsible for assuring that: - current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the residents' records; - communicated to the resident or responsible party; - educate resident or responsible party on all medication and treatment orders; and - changes in orders are addressed in the resident's service plan and are communicated to the other staff. No further information provider. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all	01880		

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01880	Continued From page 25 prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure prescription medications were stored according to the manufacturer's directions for one of one resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 the residents). The findings include: On November 18, 2024, at 7:15 a.m., surveyor observed the medication refrigerator to contain: - facility stock box of Bisacodyl rectal suppositories; and - R4's prescription Bisacodyl rectal suppositories. The manufacturer instructions located on R4 Bisacodyl prescription box indicated medication should be stored at room temperature. On November 19, 2024, at 11:00 a.m., clinical nurse supervisor (CNS)-B stated she was not aware that suppositories should be stored at room temperature, did not put the suppositories in the refrigerator, and is not sure how they got	01880		

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01880	Continued From page 26 there. CNS-B stated she would need to call the pharmacy and see if they are still okay to use or should be reordered. The licensee's 7.11 Medication Storage policy dated August 1, 2021, indicated when medications are managed and stored by the licensee, medications will be kept securely locked and stored per manufacturer's directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
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 record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment with mitigation factors on and around the property for the facility. This deficient practice had the ability to affect all staff,	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30718	A. BUILDING: _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEX ASSISTED LIVING LLC	90 EAST LAKE COWDRY ROAD NW ALEXANDRIA, MN 56308

(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
02040	Continued From page 27 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 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: A record review and interview were conducted on November 19, 2024, at 9:45 a.m., with licensed assisted living director/licensed practical nurse (LALD/LPN)-A, director of maintenance (DOM)-D and accounting director (AD)-F on the hazard vulnerability assessment for the physical environment of the facility. Record review indicated that the licensee had not performed a hazard vulnerability assessment with risk and mitigation factors on and around the property. During interview, LALD/LPN-A stated that the licensee had performed a hazard assessment for the Appendix Z requirements but had not performed a hazard vulnerability assessment for the physical environment on or around the property. The hazard vulnerability assessment should include the risks factors and what the facility plans to do to mitigate these risks. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		
02320 SS=F	144G.91 Subd. 4 (b) Appropriate care and services	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30718	A. BUILDING: _____ B. WING _____	11/20/2024

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02320	Continued From page 28 (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure unlicensed personnel (ULP)-B followed appropriate medication administration procedures. 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On November 20, 2024, at 8:00 a.m., the surveyor observed ULP-H preform medication administration to R3. ULP-H completed hand hygiene, pulled medication bubble packs out of the medication cart, checked them with the electronic medication administration record (EMAR) one time. ULP-H removed the medication from the bubble pack and placed it in a mediation cup. ULP-H completed this process with each morning medication scheduled for R3. ULP-H then administered the medications to R3.	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30718	A. BUILDING: _____ B. WING _____	11/20/2024

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02320	Continued From page 29 ULP-H had a hire date of July 10, 2015, under the home care license and began providing assisted living services on August 1, 2021. ULP-H's employee record included a competency sign off form on oral medication administration signed July 29, 2021. ULP-H's record also included a medication administration overview class completed on July 7, 2023. On November 20, 2024, at 8:00 a.m., ULP-H stated she was not aware of the six rights and three checks of medication administration and was not aware this should be completed with each medication administration. ULP-H stated she has worked at the facility for nine years, knows the medications that the residents receive, and was originally trained by the registered nurse after she was hired. On November 20, 2024, at 10:00 a.m., clinical nurse supervisor (CNS)-B stated she would expect the staff to complete the six rights and three checks of medication administration with each medication before administering them. The licensee's 7.15 Medication & Treatments - Administration & Delegation policy dated August 1, 2021, indicated when in administration of medications or treatment/therapy is delegated or assigned to ULP, the licensee will ensure that the registered nurse has: - Instructed the unlicensed personnel in the proper methods with respect to each resident to administer the medications or perform treatment/therapy, and the ULP has demonstrated the ability to competently follow the procedures; - Specified, in writing, specific instructions for each resident and documented those instructions	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ALEX ASSISTED LIVING LLC	90 EAST LAKE COWDRY ROAD NW ALEXANDRIA, MN 56308

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02320	Continued From page 30 in the residents records; and - Communicated with the unlicensed personnel about the individual needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

MN Department of Health
Food, Pools, and Lodging Services
PO Box 64975
St. Paul, MN 55164-0975
218-332-5150

Type: Full
Date: *11/19/24*
Time: 14:43:07
Report: 7935241098

Food and Beverage Establishment Inspection Report

Location:
Alex Assisted Living Llc
90 East Lake Cowdry Road Nw
Alexandria, MN56308
Douglas County, 21

Establishment Info:
ID #: 0038026
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3207628345
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Chlorine: = 100 ppm at Degrees Fahrenheit
Location: Wiping Cloth Bucket
Violation Issued: No

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: Spray Bottle
Violation Issued: No

Hot Water: = at 165 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: Cookline Bucket
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cooking
Temperature: 208 Degrees Fahrenheit - Location: Chicken
Violation Issued: No

Process/Item: Cold Holding
Temperature: 36 Degrees Fahrenheit - Location: Walk In
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: Arctic Air
Violation Issued: No

Type: Full
Date: *11/19/24*
Time: 14:43:07
Report: 7935241098
Alex Assisted Living Llc

Food and Beverage Establishment Inspection Report

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

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

I acknowledge receipt of the MN Department of Health inspection report number 7935241098 of 11/19/24.

Certified Food Protection Manager: Gustav Persons

Certification Number: 89774 Expires: 08/12/27

Signed: _____
Establishment Representative

Signed: Rebecca Tonn
Rebecca Tonneson
Public Health San Supervisor
Fergus Falls District Office
218-332-5142
rebecca.tonneson@state.mn.us