Electronically delivered

April 7, 2022

Administrator
Alex Assisted Living, LLC
90 East Lake Cowdry Road NW
Alexandria, MN 56308

RE: Project Number(s) SL30718015

Dear Administrator:

On April 5, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on November 4, 2021. The follow-up evaluation determined your agency had not corrected all of the state licensing orders issued pursuant to the November 4, 2021 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on November 4, 2021, found not corrected at the time of the April 5, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

1620-Initial Reviews, Assessments, And Monitoring-144g.70 Subd. 2 (c-E)

The details of the violations noted at the time of this follow-up evaluation completed on April 5, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

Also, at the time of this follow-up evaluation completed on April 5, 2022, we identified the following violation(s):

2310-Appropriate Care And Services-144g.91 Subd. 4

The details of the violation(s) noted at the time of this follow-up evaluation are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders. It is not necessary to develop a plan of correction.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the

correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in §144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in §144G.20.
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CORRECTION ORDER RECONSIDERATION PROCESS

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

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

We urge you to review these orders carefully. If you have questions, please contact Jodi Johnson at 507-344-2730.

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

Sincerely,

Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 507-344-2730 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30718	A. BUILDING: _____ B. WING _____	R 04/05/2022

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 Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 1144G.08 to 144G.95, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project # SL30718015 On April 4, 2022, through April 5, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on November 4, 2021, and a revisit survey on January 25, 2022. At the time of the survey, there were 26 active residents receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued and/or issued	{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 License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{01620} SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	{01620}		

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{01620}	Continued From page 1 (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to conduct an ongoing resident reassessment and monitoring that reflected the resident's current condition for one of one resident (R22) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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	{01620}		

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{01620}	Continued From page 2 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R22's diagnoses included unspecified dementia without behavioral disturbances and irritable bowel syndrome. R22's care plan last updated December 12, 2021, indicated the resident used side rails to aid in independence with bed mobility. R22's Clinical Update Assessment dated January 4, 2022, indicated R22 did not use any devices for bed mobility and was independent in bed. The most recent assessment did not accurately identify R22's current condition. R22's undated Risk Agreement-Bed Positioning Device assessment indicated the resident used the bed rail to assist with repositioning and getting out of bed. The risk agreement indicated the resident and/or responsible party understood and accepted responsibility for the possible outcomes of the agreed-upon course of action (use of bed rails). On April 4, 2022, at approximately 3:20 p.m. the surveyor observed a bedrail on the left side near the head of R22's bed. The bed rail was secured to the bed frame. The rail was a drop style and could be raised up and down, and was observed in the down position. On April 4, 2022, at approximately 3:20 p.m. registered nurse (RN)-Q confirmed R22 had a side rail on the left side near the head of her bed. RN-Q confirmed the resident independently managed the bed rail and was able to move it up	{01620}		

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{01620}	Continued From page 3 and down on her own. On April 4, 2022, at approximately 3:50 p.m. owner (O)-R stated they "were not going to comment on that" when asked if the assessment accurately reflected the resident's use of bed rails, or if the resident had been assessed to be able to safely manage the use of her bed rail. The licensee's policy, 6.03 Uniform Assessment Tool dated August 1, 2021, indicated the licensee would complete a uniform assessment that addresses all the required elements. No further information was provided.	{01620}		
02310 SS=D	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of one residents (R22) with bedrails. 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	02310		

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02310	Continued From page 4 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R22's diagnoses included unspecified dementia without behavioral disturbances and irritable bowel syndrome. R22's side rail assessment dated July 2021, indicated side rails were not indicated for use. R22's care plan updated December 12, 2021, indicated the resident used side rails to aid in independence with bed mobility. R22's Clinical Update Assessment dated January 4, 2022, indicated R22 did not use any devices for bed mobility and was independent in bed. This did not accurately reflect the resident's current status of side rail use. R22's undated Risk Agreement-Bed Positioning Device assessment indicated the resident used the bed rail to assist with repositioning and getting out of bed. The risk agreement indicated the resident and/or responsible party understands and accepts responsibility for the possible outcomes of the agreed-upon course of action (use of bed rails). R22's record lacked a side rail assessment that correctly addressed the resident's needs and capabilities, and lacked documented measurements to ensure the side rail was in compliance with FDA guidelines. On April 4, 2022, at approximately 3:20 p.m. the surveyor observed a bedrail on the left side near the head of R22's bed. The bed rail was secured	02310		

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02310	Continued From page 5 to the bed frame. The rail was a drop style and could be raised up and down, and was observed in the down position. At that time, registered nurse (RN)-Q confirmed R22 had a side rail on the left side near the head of her bed. RN-Q stated the resident independently managed the bed rail and was able to move it up and down on her own. RN-Q measured the bed rail with the surveyor present. The side rail measured 36.5 inches long by 19 inches tall. The zones of entrapment measured less than 2 inches, which was in compliance with FDA guidelines. On April 4, 2022, at approximately 3:50 p.m. owner (O)-R stated they "were not going to comment on that" when asked if the assessment accurately reflected the resident's use of bed rails or if the resident had been assessed to be able to safely manage the use of her bed rail. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (space between the rails), should be less than 4 and 3/4 inches. The FDA "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe."	02310		

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02310	Continued From page 6 The licensee's 6.28 Side rails policy dated August 1, 2021, indicated the licensee would assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of a safe design and utilized consistent with the manufacturer's directions. The policy indicated it would be followed regardless of who owns or is supplying the side rail. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days.	02310		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

TAG 1290 RESCINDED AFTER RECONSIDERATION PENALTY CHANGE FROM $5,500 TO $2,500 5/16/22

Electronically delivered

February 14, 2022

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

RE: Project Number(s) SL30718015

Dear Administrator:

On January 25, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on November 4, 2021. The follow-up evaluation determined your agency had not corrected all of the state licensing orders issued pursuant to the November 4, 2021 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on November 4, 2021, found not corrected at the time of the January 25, 2022 follow-up evaluation and/or subject to penalty assessment are as follows:

0250-Conditions-144g.20 Subdivision 1. = $500.00
0480-Minimum Requirements-144g.41 Subd 1 (13) (i) (b) = $500.00
0510-Infection Control Program-144g.41 Subd. 3 = $500.00
1390-Availability Of Contact Person To Staff-144g.62 Subdivision 1 = $500.00

The details of the violations noted at the time of this follow-up evaluation completed on January 25, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $2,500.00 ~~5,500.00~~**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

Also, at the time of this follow-up evaluation completed on January 25, 2022, we identified the following violation(s):

0340-Correction Orders-144g.30 Subd. 5 = $500.00
~~1290-Background Studies Required-144g.60 Subdivision 1 = $3,000.00 RESCINDED AFTER RECONSIDERATION 5/16/22~~

The details of the violation(s) noted at the time of this follow-up evaluation are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders. It is not necessary to develop a plan of correction.

DOCUMENTATION OF ACTION TO COMPLY

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

IMPOSITION OF FINES:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in §144G.20 for widespread violations;
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CORRECTION ORDER RECONSIDERATION PROCESS

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

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P.O. Box 64970
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St. Paul, MN 55164-0970
Health.HRD.Appeals@state.mn.us

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

We urge you to review these orders carefully. If you have questions, please contact Jodi Johnson at 507-344-2730.

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

Sincerely,

Jodi Johnson, Supervisor
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these licensing orders. It is not necessary to develop a plan of correction.

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{0 000}	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.10 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project SL30718015-1 On January 24, 2022, through January 25, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on November 4, 2021. At the time of the survey, there were 28 active residents receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued. The immediate correction order tag identification 1290, identified on Janaury 24, 2022, has been corrected as of January 24, 2022. No further action required.	{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 License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 250} SS=F	144G.20 Subdivision 1. Conditions (a) The commissioner may refuse to grant a	{0 250}		

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{0 250}	Continued From page 1	{0 250}		

provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility:
(1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules;
(2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services;
(3) performs any act detrimental to the health, safety, and welfare of a resident;
(4) obtains the license by fraud or misrepresentation;
(5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter;
(6) denies representatives of the department access to any part of the facility's books, records, files, or employees;
(7) interferes with or impedes a representative of the department in contacting the facility's residents;
(8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4;
(9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department;
(10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter;
(11) refuses to initiate a background study under section 144.057 or 245A.04;
(12) fails to timely pay any fines assessed by the

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{0 250}	Continued From page 2 commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the management officials who were in charge of the day-to-day operations; and responsible for the resident's assisted living services, understood all of the assisted living facility with dementia care regulations. This had the potential to affect all 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 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 24, 2022, at approximately 11:00 a.m. registered nurse (RN)-O provided a partial copy of the licensee's plan of correction. RN-O stated she thought they had corrected everything; however, she was only onsite one day a week, so	{0 250}		

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{0 250}	Continued From page 3 she was unsure what actions had been taken. The licensee had attested they read and understood the Assisted Living with Dementia Care licensing statutes and rules upon application; however, the following orders were issued: Refer to licensing order at 144G.40 Subd. 2. The licensee failed to update it's uniform checklist disclosure of assisted living services when it changed services it offered and failed to provide a copy of the updated UDALSA to all residents. Refer to licensing order at 144G.41 Subd. 1. The licensee failed to ensure food was prepared and served according to the Minnesota Food Code. Refer to licensing order at 144G.41 Subd. 3. The licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to COVID-19, when they did not comply with MDH guidance for COVID-19 related to wearing appropriate PPE (personal protective equipment) and following appropriate infection control processes for isolation rooms. Refer to licensing order at 144G.50 Subd. 5. The licensee failed to ensure the assisted living contract did not include waivers of liability. Refer to licensing order at 144G.60 Subd. 1. The licensee failed to ensure a background study was submitted and received for one of one employee (registered nurse (RN)-O). This resulted in an immediate correction order on January 25, 2022 at 8:48 a.m., and was corrected as a result of submitting the background study on January 24,	{0 250}		

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{0 250}	Continued From page 4 2022. Refer to licensing order at 144G.62 Subd. 1. The facility failed to have a registered nurse available for consultation by staff performing delegated nursing tasks Refer to licensing order at 144G.70 Subd. 2. The licensee failed to conduct an ongoing resident reassessment and monitoring that reflected the residents current condition for one of one resident (R5) with records reviewed. Refer to licensing order at 144G.70 Subd. 4. The licensee failed to ensure the service plan included the required content for two of four residents (R1, R2) with records reviewed. Refer to licensing order at 144G.71 Subd. 2. The licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment, prior to providing medication management services, to include all required content for three of four residents (R1, R2, R5) with records reviewed. Refer to licensing order at 144G.71 Subd. 5. The licensee failed to develop and maintain a current individualized medication management record to include all required content for one of four residents (R1) with record reviewed. Refer to licensing order at 144G.71 Subd. 13. The licensee failed to ensure written or electronically recorded prescriptions were obtained for one of four residents with records reviewed. Refer to licensing order at 144G.72 Subd. 5. The licensee failed to document treatment	{0 250}		

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{0 250}	Continued From page 5 administration for two of three residents (R1, R5) receiving treatments. Refer to licensing order at 144G.72 Subd. 3. The licensee failed to develop a treatment management plan to include all required content for two of three residents receiving services (R1, R5) with records reviewed. Refer to licensing order at 144G.72 Subd. 6. The licensee failed ensure up-to-date written or electronically recorded orders were maintained for two of three residents receiving treatments. Nine (9) correction orders were reissued and six (6) new orders were issued, which indicated the licensee's understanding of the Minnesota statutes and Rules was limited or not evident for compliance with sections 144G.10 to 144G.95. No further information was provided.	{0 250}		
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or e-mail copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public	0 340		

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0 340	Continued From page 6 documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with the correction orders for a survey completed on November 4, 2021, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a 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, 2022, at approximately 11:00 a.m. registered nurse (RN)-O provided a partial copy of the licensee's plan of correction. RN-O stated she thought they had corrected everything but she was only on site one day a week so was not sure what actions had been taken. During the revisit survey on January 24 through January 25, 2022, a review of the licensee's	0 340		

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0 340	Continued From page 7 policies and procedures, resident records, and employee records lacked evidence to indicate the licensee had corrected all the orders issued on November 4, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
{0 430} SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to update its uniform checklist disclosure of assisted living services (UDALSA)	{0 430}		

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{0 430}	Continued From page 8 when it changed services offered and failed to provide a copy of the updated UDALSA to all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect 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: On January 24, 2022, at approximately 11:00 a.m. an updated copy of the licensee's UDALSA was requested. The licensee's UDALSA dated May 21, 2021, indicated insulin pen dosing was provided by the licensee, but they would not provide subcutaneous injections. R2's diagnoses included, but were not limited to, Alzheimer's disease, hypertension, and anxiety. R2's Individual Medication Management Plan (IMMP) indicated subcutaneous injections would not be delegated to unlicensed personnel. R2's signed prescriber orders dated January 18, 2022, indicated R2 received 1.8 milligrams (mg) of Liraglutide Solution Pen Injector 18mg/3 milliliters (mL) once a day for type two diabetes. R2's Medication Administration Record (MAR) indicated unlicensed personnel (ULP) administered R2's subcutaneous injection 25 times in January.	{0 430}		

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{0 430}	Continued From page 9 On January 24, 2022, at approximately 2:25 p.m. licensed practical nurse (LPN)-J stated she thought the UDALSA had been updated since their survey in November and that they were now providing subcutaneous injections and insulin injections if staff had been trained to do so. LPN-J did not know what date the UDALSA was updated and did not know if there was any documentation to show residents received an updated copy of the UDALSA. On January 25, 2022, at approximately 10:15 a.m. ULP-E stated R2 can sometimes self administer her own injections, but the ULP often administer it for her. ULP-E was not aware R2's IMMP indicated subcutaneous injections were not to be delegated to unlicensed personnel. On January 25, 2022, at approximately 11:30 a.m. registered nurse (RN)-O stated she thought R2 was administering her own insulin and was not aware the IMMP indicated staff were not to administer subcutaneous injections. RN-O was not aware the UDALSA had not been updated to reflect the correct services the licensee provides. On January 25, 2022, at approximately 11:05 a.m. LPN-C stated the UDALSA was updated yesterday (January 24, 2022) and had not been distributed to residents or their representatives yet. LPN-C stated the UDALSA was updated to include the change that unlicensed personnel will provide subcutaneous injections/insulin injections. LPN-C indicated the licensee had updated it's policies and was allowing trained ULP to administer subcutaneous injections. A policy regarding services available on the UDALSA was requested, but not provided.	{0 430}		

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{0 430}	Continued From page 10 No further information was provided.	{0 430}		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	{0 480}		

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{0 480}	Continued From page 11 The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated January 25, 2022, for the specific Minnesota Food Code deficiencies.	{0 480}		
{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to COVID-19. This had the potential to affect all 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), and was issued at a widespread scope (when problems are pervasive	{0 510}		

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{0 510}	Continued From page 12 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: MASK REUSE On January 24, 2022, at approximately 10:40 a.m. a shelving unit was observed near the entrance to the facility. The shelving unit contained bins labeled with staff members' names and contained brown paper bags for N95 masks to be stored. On January 24, 2022, at approximately 1:10 p.m. unlicensed personnel (ULP)-I stated staff were to get a new surgical mask daily but they would reuse their N95 for about five days. ULP-I stated they would track it by how many days they worked and some people wrote the dates on the bags. On January 24, 2022, at approximately 1:20 p.m. licensed practical nurse (LPN)-J stated staff were to dispose of their N95 masks daily and the procedure was to not reuse N95 masks. On January 24, 2022, at approximately 1:50 p.m. registered nurse (RN)-O stated staff should not be reusing N95 masks more than one day and thought the storage unit by the entrance to the facility was where staff stored their initial N95 they got after being fit tested. On January 24, 2022, at approximately 2:45 p.m. ULP-P stated staff would reuse their N95 masks "a couple of times." ULP-P stated they would put their used N95 in a paper bag in a bin in the shelving unit at the end of their shift.	{0 510}		

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{0 510}	Continued From page 13 On January 25, 2022, at approximately 10:15 a.m. ULP-E stated staff were instructed to reuse their N95 masks and they were to store them in a paper bag at the end of their shift. INFECTION CONTROL ISOLATION PRACTICES On January 25, 2022, at approximately 9:40 a.m. the door of a resident in isolation for COVID-19 was observed to be open. ULP-P was observed to be in the resident's room administering medications to the resident. The door was observed to be open for approximately two minutes. On January 25, 2022, at approximately 9:50 a.m. RN-O stated her expectation would be staff would immediately close the door of a COVID-19 isolation room and not leave it open for extended periods of time. RN-O further stated "that's the point of isolation, if the door is open, it should be quick." Centers for Disease Control guidance dated September 10, 2021, indicated when masks are used for source control for health care workers, the mask could be used for the entire shift unless it became soiled, damaged, or hard to breathe through. The guidance indicated if masks are used during the care of patient for which a facemask is indicated for personal protective equipment, they should be removed and discarded after the patient care encounter and a new one should be donned. The licensee's policy, 4.35 COVID-19 updated December 6, 2021, indicated PPE would be changed daily or as needed if soiled. The policy	{0 510}		

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{0 510}	Continued From page 14 indicated residents on droplet and contact precautions would be quarantined in their room with the door closed. No further information was provided.	{0 510}		
{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 interview and record review, the facility failed to ensure the contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On January 24, 2022, at approximately 10:45 a.m. an updated copy of the licensee's contract	{0 970}		

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{0 970}	Continued From page 15 was requested. The contract included two clauses that indicated the resident would waive the licensee's liability for health, safety, or personal property of a resident. Page 15, section 2. of the contract indicated a resident would indemnify or hold harmless the provider, it's employees and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by resident of the rented premises or any other part of the provider's property, or caused wholly or in part by an act or omission of resident or resident's guests or agents. On January 25, 2022 at approximately 3:00 p.m., registered nurse (RN)-O stated she was not sure if the contact had been updated but verified the one provided to the surveyor was the current copy being used. A policy on content of assisted living contracts was requested, but not provided. No further information was provided.	{0 970}		
01290 SS=G	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be	01290		

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01290	Continued From page 16 classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was submitted and received for one of one employee (registered nurse (RN)-O) with records reviewed. This resulted in an immediate correction order on January 24, 2022. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: RN-O was hired on December 30, 2021, to provide supervision of unlicensed personnel and residents as well as provide direct care services to residents at the assisted living with dementia care facility. RN-O's employee record lacked documentation of a submitted and received background study prior to RN-O providing care, services and supervision of unlicensed personnel and residents.	01290		

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01290	Continued From page 17 On January 24, 2022, at 3:45 p.m. RN-O stated she had a background study completed for the sister facility, with a different license number, and believed a background study was submitted for this license; however, she stated she would verify with licensed assisted living director (LALD)-A. On January 24, 2022, at 4:05 p.m. RN-O provided a background study for herself for this license. The background study submission date was January 24, 2022. RN-O stated she was unsure when the background study had been completed, stating LALD-A had sent her the background study provided. The licensee's 4.02 Background Studies policy dated August 1, 2021, noted no employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study have been received. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate This immediate correction order identified on January 24, 2022, has been corrected as of January 24, 2022. This was confirmed by the surveyor's onsite record review and approved by the evaluation supervisor. No further action required.	01290		
{01390} SS=F	144G.62 Subdivision 1 Availability of contact person to staff (a) Assisted living facilities must have a registered nurse available for consultation by staff performing delegated nursing tasks and must	{01390}		

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{01390}	Continued From page 18	{01390}		

have an appropriate licensed health professional available if performing other delegated services such as therapies.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to have a registered nurse (RN) available for consultation by staff performing delegated nursing tasks. This had the potential to affect all residents.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

On January 24, 2022, at approximately 10:44 a.m. RN-O confirmed she was the RN on call 24 hours a day, seven days a week.

On January 25, 2022, at approximately 10:15 a.m. unlicensed personnel (ULP)-P stated sometimes the nurse they call with questions was a licensed practical nurse (LPN).

On January 25, 2022, at approximately 11:10 a.m. RN-O stated they do utilize LPNs in the call rotation. RN-O stated the LPNs would triage the issue and call the RN if warranted. RN-O stated the LPNs would not call her with "the piddily stuff, little things they don't need to update me on." RN-O stated this could include things like a resident wandering as the LPN could offer an

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{01390}	Continued From page 19 intervention and handle the situation. The licensee's nurse on-call schedule for January indicated the scheduled on-call nurse for most days was a licensed practical nurse, and not a registered nurse. The licensee's 6.12 Availability of an RN for Staff policy dated August 1, 2021, indicated a registered nurse must be available for consultation by staff performing delegated nursing tasks, must be readily available either in person, by telephone, or by other means to the staff at all times when the staff are providing services. No further information was provided.	{01390}		
01620 SS=D	144G.70 Subd. 2 Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident	01620		

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of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to conduct an ongoing resident reassessment and monitoring that reflected the resident's current condition for one of one resident (R5) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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:

FALLS
R5's diagnoses included, but were not limited to, Alzheimer's disease, anxiety disorder, and muscle weakness.

R5's service plan dated July 29, 2021, indicated the resident required assistance with dressing, feeding, oral hygiene, hair care, grooming, toileting, weekly laundry and housekeeping, and a three times daily "I'm OK" check.

R5's Uniform Assessment Tool dated December 14, 2021, indicated R5 was at risk for falls, but

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had not had any falls in the past 90 days; however, elsewhere R5's record contained documentation of two falls that had occurred in the past 90 days.

R5's record included an incident report dated December 31, 2021. The incident report included the following information:
-December 31, 2021, at approximately 1:00 a.m. R5 was found on the floor, lying on her fall mat next to the bed. The incident report noted staff reported R5 had been restless that night. The incident report indicated a small abrasion was sustained to R5's "thumb and pointer finger". R5 was given Ativan after the fall. Intervention: bed alarm placed, rolled blanket put under fitted sheet on the side of the bed that is not against the wall to aid in redirect resident from self transfer and allow staff time to respond to bed alarm.

On January 25, 2022, at approximately 2:45 p.m. registered nurse (RN)-O confirmed that R5's December 14, 2021 assessment was not accurate indicating R5 had not had any falls in the previous 90 days and confirmed at the time of the assessment, R5 had two falls. In addition, RN-O confirmed a root cause analysis by the RN was not completed after R5's fall on December 31, 2021. RN-O stated if she thought the incident report was good, she would just lock the report. RN-O stated she was not instructed to do a big root cause analysis like the nursing home does and that it would not be their normal practice to do a root cause analysis after every fall, especially if there was no injury. RN-O stated, "It's not that we don't do it on every fall, we just don't do it on everyone." RN-O stated sometimes they'd discuss what happened after a fall, but since "this is assisted living, we don't do the whole analysis like a nursing home, they're

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01620	Continued From page 22 different." PRESSURE ULCERS R5's Uniform Assessment Tool dated December 14, 2021, indicated the resident's skin was warm, pink, moist and had normal turgor. The assessment indicated the resident did not have any current skin concerns. R5's record included the following progress notes: -December 1, 2021, a note by licensed practical nurse (LPN)-C indicated R5 was seen at the clinic for follow up on her bilateral heel pressure ulcers. The note indicated the right heel was debrided and was diagnosed as a stage 3 pressure ulcer. The left heel was noted be a stage 2 pressure ulcer. -December 13, 2021, a note by LPN-C indicated the wound care nurse visited R5 and changed the dressing on R5's bilateral heel wounds. -December 16, 2021, a note by LPN-C indicated R5 was seen at the clinic for a follow up visit for the resident's bilateral heel ulcers. The note indicated the right heel was a stage 3 pressure ulcer and the left heel was a stage 2 pressure ulcer. On January 25, 2022, at approximately 2:55 p.m. RN-O stated she was not sure if R5 had any current skin conditions. RN-O reviewed R5's chart and confirmed the December 14, 2021, assessment was not accurate and that R5 had bilateral pressure ulcers to her heels. RN-O stated assessments were done in person, and it would be expected the nurse completing the assessment review the resident's recent provider notes and physically assess the resident. RN-O was not sure if that happened with R5's December 14, 2021, assessment.	01620		

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01620	Continued From page 23 On January 25, 2022, at approximately 3:30 p.m. R5 was observed to have bilateral heel pressure ulcers. The licensee's policy, 6.03 Uniform Assessment Tool dated August 1, 2021, indicated the licensee would complete a uniform assessment that addresses all the required elements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=D	144G.70 Subd. 4 Service plan, implementation, and revisions t (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has	01650		

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01650	Continued From page 24 authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included the required content for two of four residents (R1, R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R1's diagnoses included, but were not limited to, dementia and stage three chronic kidney disease. R1's service plan dated July 26, 2021, did not indicate the resident received treatment management services. R1's treatment management plan dated December 10, 2021, indicated the resident received oxygen management services. R1's service plan lacked the following required content for the treatment services the resident was receiving:	01650		

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01650	Continued From page 25 - a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; - the identification of staff or categories of staff who will provide the services; R2's diagnoses included, but were not limited to, type two diabetes, hyperlipidemia, major depressive disorder, and vascular dementia. R2's service plan did not include assistance with compression stockings. R2's treatment management plan dated January 4, 2022, indicated the resident received assistance with compression garments. R2's service plan lacked the following required content for the treatment services the resident was receiving: - a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; and - the identification of staff or categories of staff who will provide the services On January 25, 2022, at approximately 11:20 a.m. registered nurse (RN)-O confirmed the service plan did not reflect all the services R1 and R2 were receiving. The licensee's policy, 6.10 Service Plan Modifications dated August 1, 2021, indicated a service plan modification form would be completed when a change to the service plan occurs. No further information was provided.	01650		

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01650	Continued From page 26 TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
{01700} SS=E	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse	{01700}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{01700}	Continued From page 27 (RN) conducted a face-to-face medication management assessment, prior to providing medication management services, to include all required content for three of four residents (R1, R2, R5) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R1 R1's diagnoses included, but were not limited to, dementia and stage three chronic kidney disease. R1's service plan dated July 26, 2021, indicated the resident received medication management services. R1's medication management assessment dated December 11, 2021, lacked the following required content: - indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues; - interventions needed in management of medications to prevent diversion of medication by others who may have access to the medications; and - instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent	{01700}		

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{01700}	Continued From page 28 diversion of medications. R2 R2's diagnoses included, but were not limited to, Alzheimer's disease, hypertension, and anxiety. R2's service plan dated July 20,2021, indicated the resident received medication management services. R2's medication management assessment dated January 4, 2022, lacked the following required content: - an identification and review of all medications the resident is known to be taking; - indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues; - interventions needed in management of medications to prevent diversion of medication by others who may have access to the medications; and - instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. R5 R5's diagnoses included, but were not limited to, Alzheimer's disease, anxiety disorder, and muscle weakness. R5's service plan dated July 29, 2021, indicated the resident received medication management services. R5's medication management assessment dated December 14, 2021, lacked the following required content: - indications for medications, side effects,	{01700}		

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{01700}	Continued From page 29 contraindications, allergic or adverse reactions, and actions to address these issues; - interventions needed in management of medications to prevent diversion of medication by others who may have access to the medications; and - instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. On January 25, 2022, at approximately 11:25 a.m. RN-O confirmed R1, R2, and R5's medication management assessments did not contain all the required information. The licensee's policy, 7.01 Medication Management- Assessment, Monitoring & Reassessment dated August 1, 2021, indicated a registered nurse would conduct an assessment to determine what medication management services would be provided and how the services would be provided. No further information was provided.	{01700}		
{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:	{01730}		

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{01730}	Continued From page 30 (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain a current individualized medication management record to include all required content for one of four residents (R2) with record reviewed.	{01730}		

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{01730}	Continued From page 31 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 included: R2's diagnoses included, but were not limited to, Alzheimer's disease, hypertension, and anxiety. R2's record included an Individual Medication Management Plan (IMMP) dated January 4, 2022. The IMMP lacked the following: - documentation of specific resident instructions related to the administration of medications; and - identification of medication management tasks that may be delegated to unlicensed personnel R2's IMMP lacked specific instructions related to monitoring blood sugar to include paramaters of when to call the nurse for low blood sugar and if R2's Liraglutide should be held. R2's Uniform Assessment Tool dated January 4, 2022, indicated R2 was not able to safely self administer medications due to the resident's diagnosis of Alzheimer's disease. R2's signed prescriber orders dated January 18, 2022, indicated R2 recieved 1.8 milligrams (mg) of Liraglutide Solution Pen Injector 18mg/3 milliliters (mL) once a day for type two diabetes. R2's Medication Administration Record (MAR) indicated ULP administered R2's subcutaneous	{01730}		

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{01730}	Continued From page 32 injection 25 times in January. On January 25, 2022, at approximately 10:15 a.m. ULP-E stated R2 can sometimes self-administer her own injections but the ULP often administer it for her. ULP-E was not aware R2's IMMP indicated subcutaneous injections were not to be delegated to ULP. ULP-E stated she hadn't seen any instructions on when the nurse should be contacted if the resident's blood sugar was too low, or when they should not administer insulin. ULP-E stated she would probably call the nurse if the resident's blood sugar was below 100. On January 25, 2022, at approximately 11:30 a.m. registered nurse (RN)-O confirmed the IMMP was missing some of the required content. RN-O thought R2 was administering her own insulin and was not aware the IMMP indicated staff were not to administer subcutaneous injections. RN-O stated the doctor hadn't ordered any specific paramaters and they had not requested any to be added. The licensee's 7.03 Medication Management Individualized Plan policy dated August 1, 2021, indicated the medication management record would contain all the required content. No further information provided.	{01730}		
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.	01820		

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01820	Continued From page 33 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of four residents (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R1 R1's diagnoses included, but were not limited to, dementia and stage three chronic kidney disease. R1's service plan dated July 26, 2021, indicated the resident received medication management services. R1's medication administration record (MAR) for January 2022, indicated R1 received Robinul/glycopyrrolate (a medication for mucous build up). R1's prescriber's orders dated August 3, 2021, did not contain a signed order for Robinul/glycopyrrolate. On January 25, 2022, at approximately 11:20 a.m. registered nurse (RN)-O stated she was not sure why the orders did not include	01820		

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01820	Continued From page 34 Robinul/glycopyrrolate, but RN-O thought hospice had ordered it. The licensee's policy, 7.20 Medication and Treatment Orders dated August 1, 2021, indicated a current, written prescriber's order would be obtained for any treatment or medication administration provided to a resident. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	01820		
{01940} SS=E	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy	{01940}		

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{01940}	Continued From page 35	{01940}		

received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to develop a treatment management plan to include all required content for three of four residents receiving treatments (R1, R5 and R21) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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:
R1
R1's diagnoses included, but were not limited to, dementia and stage three chronic kidney disease.

R1's service plan dated July 26, 2021, did not indicate the resident received treatment management services. R1's treatment management plan dated December 10, 2021, indicated the resident received oxygen management services.

R1's medication administration record (MAR) for January 2022, indicated R1 received the

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{01940}	Continued From page 36	{01940}		

following:
- two (2) liters by nasal cannula as needed (PRN) for shortness of breath, difficulty breathing
- 2 liters by nasal cannula at bedtime for comfort per hospice

R1's prescriber's orders dated August 3, 2021, indicated the resident had the following signed orders for oxygen:
- 2 to 4 (four) liters PRN for comfort dyspnea (shortness of breath)

R1's treatment management plan lacked the following required content:
- procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and
- any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.

On January 25, 2022, at approximately 10:15 a.m. unlicensed personnel (ULP)-E stated she was not sure when she would contact the nurse if R1's oxygen levels were low. ULP-E stated she would probably call the nurse if the resident's oxygen was below 90% but stated there was not any specific procedure of when to update the nurse.

On January 25, 2022, at approximately 11:20 a.m. registered nurse (RN)-O confirmed R1's treatment management plan did not contain the

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{01940}	Continued From page 37 required content and lacked details specific to the resident's oxygen management. R5 R5's diagnoses included, but were not limited to, Alzheimer's disease, anxiety disorder, and muscle weakness. R5's service plan dated July 29, 2021, did not indicate the resident received treatment management services. R5's chart lacked evidence a treatment management plan had been developed. R5's prescriber's orders dated January 4, 2022, indicated the resident had the following orders for pressure relief to both heels: - Prevalon bootie to left foot when out of bed; and - Procare Podus boot to right foot on in the morning and off at night R5's MAR indicated staff were placing the Prevalon and Procare boots to both feet as ordered every day in January 2022. On January 25, 2022, at approximately 11:20 a.m. RN-O confirmed R5's record did not contain a treatment management plan for the resident's pressure relieving boots. R21 R21's diagnoses included anemia, type II diabetes mellitus, delusional disorders and pain. R21's prescriber orders dated January 17, 2022, included an order to change accuchecks to twice a week and as needed (PRN). R21's service plan dated July 20, 2021, lacked identification R21 was receiving services to	{01940}		

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{01940}	Continued From page 38 include blood glucose monitoring, as required. R21's Individualized Treatment/Therapy Management Plan dated January 20, 2022, indicated R21 received treatments to include blood glucose monitoring. R21's Treatment Administration Record (TAR) dated January 1 through January 24, 2022, indicated R21 received blood glucose checks every Tuesday and Friday and PRN. On January 25, 2022, at 11:10 a.m. licensed practical nurse (LPN)-C stated she would locate the service plan addendum with the blood glucose services; however, the information provided did not include blood glucose services. The licensee's policy, 7.15 Medications & Treatment-Administration & Delegation, dated August 1, 2021, indicated the RN would conduct a face to face assessment to determine what treatment services will be provided and the service plan would include a written statement of treatment services that would be provided to the resident. No further information was provided.	{01940}		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as	01960		

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01960	Continued From page 39	01960		

ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to document treatment administration for two of three residents (R1, R5) receiving treatments.

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:

R1
R1's diagnoses included, but were not limited to, dementia and stage three chronic kidney disease.

R1's service plan dated July 26, 2021, did not indicate the resident received treatment management services. R1's treatment management plan dated December 10, 2021, indicated the resident received oxygen management services.

R1's prescriber's orders dated August 3, 2021, indicated the resident had the following signed orders for oxygen:
-2 to 4 liters as needed (PRN) for comfort dyspnea (shortness of breath)

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01960	Continued From page 40 R1's medication administration record (MAR) for January 2022, indicated R1 received the following: - Two (2) liters by nasal cannula as needed (PRN) for shortness of breath, difficulty breathing -2 liters by nasal cannula at bedtime for comfort per hospice On January 25, 2022, at approximately 11:20 a.m. registered nurse (RN)-O stated she was not sure why the oxygen orders did not match what was listed in the MAR. RN-O was not able to locate any additional orders from hospice that would indicate orders for R1's oxygen had been changed. R5 R5's diagnoses included, but were not limited to, Alzheimer's disease, anxiety disorder, and muscle weakness. R5's service plan dated July 29, 2021, did not indicate the resident received treatment management services. R5's chart lacked evidence a treatment management plan had been developed. R5's prescriber's orders dated January 4, 2022, indicated the resident had the following orders for pressure relief to both heels: - Prevalon bootie to left foot when out of bed - Procare Podus boot to right foot on in the morning and off at night R5's MAR indicated staff were placing the Prevalon and Procare boots to both feet as ordered every day in January 2022. On January 24, 2022, at approximately 2:45 p.m.	01960		

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01960	Continued From page 41 unlicensed personnel (ULP)-P stated R5 does not use the Prevalon boots anymore and staff have been using a different kind of boots to both feet when out of bed. On January 25, 2022, at approximately 8:30 a.m. R5 was observed to not be wearing the boots that were ordered, and was observed to be wearing a different kind of boot to both feet. On January 25, 2022, at approximately 10:15 a.m. ULP-E stated she wasn't sure if R5 had ever used a Prevalon boot and they have been using a different type of boot to both feet "for a while." On January 25, 2022, at approximately 11:10 a.m. licensed practical nurse (LPN)-C stated R5 had new pressure relieving boots ordered and they did not arrive until January 4, 2022. LPN-C confirmed the order and MAR were not updated, and staff were incorrectly documenting which boots they were applying to R5's feet. The licensee's policy, 7.20 Medication and Treatment Orders dated August 1, 2021, indicated a current, written prescriber's order would be obtained for any treatment or medication administration provided to a resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01960		

Minnesota Department of Health

PO Box 64495
St Paul, Minnesota
651-201-4500

Type: Follow-Up
Date: *01/25/22*
Time: 10:20:37
Report: 1008221002

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.

The following orders previously issued on 11/02/21 have NOT been corrected.

5-200B Plumbing: cross connections

5-203.14 ** Priority 1 **

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

THERE IS A Y CONNECTOR ON THE FAUCET ON THE THREE COMPARTMENT SINK. A BLACK HOSE IS CONNECTED TO BOTH SIDES OF THE Y. AT THE END OF ONE OF THE HOSES IS A BACKFLOW PREVENTER WHERE IT CONNECTS TO A CHEMICAL DISPENSER. CONTINUED IN GENERAL COMMENTS.

Issued on: 11/02/21 *Comply By: 11/03/21*

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

THE SERVICE KITCHEN THAT HAS DOMESTIC EQUIPMENT AND CABINETRY SHALL DISCONTINUE SERVING TCS (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) FOODS THAT ARE HELD FOR MORE THAN SAME-DAY SERVICE. CONTINUED IN GENERAL COMMENT.

Issued on: 11/02/21 *Comply By: 11/02/21*

Type: Follow-Up
Date: *01/25/22*
Time: 10:20:37
Report: 1008221002
Alex Assisted Living Llc

Food and Beverage Establishment Inspection Report

No NEW orders were issued during this inspection.

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

THIS INSPECTION WAS CONDUCTED AS A FOLLOW-UP. ALL ORDERS EXCEPT TWO WERE CLEARED. CONTINUE TO WORK ON THE LAST TWO ORDERS.

CONTINUED FROM 4-201.11GMN: FOOD THAT IS TCS SHALL BE PREPARED AND TRANSPORTED TO THE SERVICE KITCHEN FOR SERVICE ONLY. NO TCS FOOD SHALL BE STORED IN THE REFRIGERATOR IN THE SERVICE KITCHEN. REMOVE/DISCARD FROM THE ESTABLISHMENT ALL TCS FOOD WITHIN THE REFRIGERATOR IN THE SERVICE KITCHEN.

CONTINUED FROM 5-203.14: THE OTHER SIDE OF THE Y IS AN OPEN ENDED HOSE THAT SITS IN THE BOTTOM OF THE SINK. RELOCATE THE BACKFLOW PREVENTER SO THAT IT IS ABOVE THE Y CONNECTOR SO THAT IT PROTECTS BOTH SIDES OF THE Y.

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 1008221002 of 01/25/22.

Certified Food Protection Manager: Freida M Hopkins

Certification Number: FM108730 Expires: 11/11/24

Signed: emailed to HRD
Establishment Representative

Signed: Inspector ID# 1088

Public Health Sanitarian 3
Fergus Falls District Office
651-201-4500
health.foodlodging@state.mn.us

Electronically Delivered

December 6, 2021

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

RE: Project Number(s) SL30718015-0

Dear Administrator:

The Minnesota Department of Health completed an evaluation on November 4, 2021, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

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

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

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

St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services - $3,000.00
St - 0 - 2320 - 144g.91 Subd. 4 - Appropriate Care And Services = $3,000.00

The total amount you are assessed is $6,000.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys. 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 client(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's clients/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.

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

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14, a request for a hearing must be in writing and received by the Department of Health within 15 calendar days. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

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

Sincerely,

Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 507-344-2730 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30718	A. BUILDING: _____ B. WING _____	11/04/2021

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 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: SL30718015 On November 2, 2021, through November 4, 2021, 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 28 residents receiving services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 250 SS=F	144G.20 Subdivision 1. Conditions (a) The commissioner may refuse to grant a	0 250		

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0 250	Continued From page 1 provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the	0 250		

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0 250	Continued From page 2 commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the management officials who were in charge of the day-to-day operations; and responsible for the resident's assisted living services, understood all of the assisted living facility with dementia care regulations. This had the potential to affect all 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on November 2, 2021, at 12:15 p.m. licensed assisted living director (LALD)-A and registered nurse (RN)-B confirmed they were responsible for and participated in the day-to-day operations and	0 250		

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0 250	Continued From page 3 were familiar with the Assisted Living with Dementia Care licensing rules. The licensee had attested they read and understood the Assisted Living with Dementia Care licensing statutes and rules upon application, however, the following orders were issued: The facility failed to implement the following required policies and procedures: - requirements in section 626.557, reporting of maltreatment of vulnerable adults; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; - orientation to and implementation of the assisted living bill of rights; - infection control practices; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Center for Disease Control and Prevention standards; and - medication and treatment management Refer to licensing order at Statute 144G.41, Subd. 3. The licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to COVID-19, when they did not comply with	0 250		

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0 250	Continued From page 4 MDH guidance for COVID-19 related to wearing appropriate PPE (personal protective equipment). Refer to licensing order at Statute 144G.42, Subd. 6 and 626.557, Subd. 3. The licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment and complete a thorough investigation for two of two residents (R5 and R19). Refer to licensing order at Statute 144G.42, Subd. 9. The licensee failed to ensure the provider established and maintained a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) current screening for active or latent TB for one of three employees (RN-B). In addition, the licensee failed to ensure TB training was completed for one of three employees (RN-B). Refer to licensing order at 144G.60, Subd. 5. The licensee failed to ensure contracted staff met all requirements required for personnel employed by the facility for one of one unlicensed personnel (ULP-H). Refer to licensing order at Statute 144G.63, Subd. 1. The licensee failed to ensure all required content of orientation was provided to one of three employees (RN-B). Refer to licensing order at 144G.63, Subd. 5. The licensee failed to ensure all staff received dementia care as required for two of two employees (RN-B, ULP-G). Refer to licensing order at Statute 144G.71, Subd. 2. The licensee failed to ensure the RN	0 250		

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0 250	Continued From page 5 had assessed three of three residents (R1, R2, R3) prior to initiating medication management services. Refer to licensing order at Statute 144G.71, Subd. 5. The licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for three of three residents (R1, R2, R3). Refer to licensing order at Statue 144G.71, Subd. 10. The licensee failed to ensure a written procedure was developed for medication management when residents had unplanned time away. Refer to licensing order at Statute 144G.71, Subd. 19. The licensee failed to ensure medications were stored according to manufacturer's instructions for one of one medication refrigerator. Refer to licensing order at Statute 144G.71, Subd. 20. The licensee failed to ensure medications were maintained with the open date and the expiration date for time sensitive medications for six of six residents (R2, R3, R7, R11, R12 and R13). Refer to licensing order at Statute 144G.72, Subd. 3. The licensee failed to maintain documentation of treatment administration for two of two residents (R1 and R3). Refer to licensing order at Statute 144G.72, Subd. 6. The licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of two residents (R1) receiving treatments.	0 250		

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0 250	Continued From page 6 Refer to licensing order at 144G.82, Subd. 2. The licensee failed to maintain a dignified dining experience for three of three residents requiring assistance with meals (R1, R5, R20) with records reviewed. Refer to licensing order at 144G.83, Subd. 1. The licensee failed to ensure staff working in the dementia care unit were trained in person-centered care approach for one of one unlicensed personnel (ULP-H). Refer to licensing order at 144G.91, Subd. 4 (a). The licensee failed to ensure the care and services were provided according to a suitable and up-to-date plan, and subject to acceptable health care and medical, or nursing standards for one of one resident with pressure ulcers (R5) and two of three residents with side rails (R1 and R2), with records reviewed. In addition, the licensee failed to ensure new interventions related to the root cause of falls were implemented for two of nine residents (R5 and R15) who had fallen. Refer to licensing order at 144G.91, Subd. 4 (b). The licensee failed to properly train and to ensure competency in knowing when to notify the RN of resident related changes in condition for two of two employees (ULP-I and licensed practical nurse (LPN)-J. Twenty-six (26) correction orders were issued, which indicated the licensee's understanding of the Minnesota statutes and Rules were limited or not evident for compliance with sections 144G.08 to 144G.95. No further information was provided.	0 250		

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0 250	Continued From page 7 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 250		
0 430 SS=E	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide all services as indicated available on the Uniform Checklist Disclosure of Services (UDALSA) for two of two residents (R2 and R5) who required insulin dosing and wound care. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 430		

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0 430	Continued From page 8 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: The licensee's UDALSA dated May 21, 2021, indicated insulin pen dosing was provided by the licensee, but would not provide injections. It also included basic wound care per recommendation of doctor's order. R2 R2's Service Plan dated July 20, 2021, indicated the resident received medication management services. R2 did not have a medication management plan. On November 3, 2021, at approximately 8:30 a.m. unlicensed personnel (ULP)-G was observed to have R2 dial up her insulin pen. ULP-G stated this was done because ULP were not permitted to dial up the insulin pen. ULP-G was observed to then administer the insulin injection to R2. On November 3, 2021, at approximately 12:40 p.m. registered nurse (RN)-B confirmed ULP were not to dial up insulin pens, but can administer the insulin injections. This is different than what was noted on the UDALSA. R5	0 430		

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	30718	A. BUILDING: _____ B. WING _____	11/04/2021

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0 430	Continued From page 9 R5's Service Plan dated July 29, 2021, indicated the resident required assistance with dressing, feeding, oral hygiene, hair care, grooming, toileting, weekly laundry and housekeeping, and a three times daily "I'm OK" check. A progress note completed by LPN-B dated October 27, 2021, indicated R5 had stage one pressure ulcers to both heels. No further notes were entered after this date and measurements were not obtained. The note further indicated home health wound care was to evaluate and treat. During an interview on November 3, 2021, at approximately 12:00 p.m. registered nurse (RN)-B stated R5 had unstageable, intact pressure ulcers to both heels and a contracted home health agency was managing the wound care for R5. RN-B confirmed no measurements had been taken and no documentation was done after October 27, 2021, because the licensee did not manage wound care. On November 3, 2021, at 12:30 p.m. RN-B stated she was told "we try to stay away from nursing care" by licensed practical nurse (LPN)-C "so we try not to do nursing stuff and have home care do it instead." RN-B stated since she was only onsite two days a week, she had not had a chance to assess R5's heels this week. RN-B further indicated she was not aware the wound had opened up on the right heel, and was not sure if the home care agency had been able to assess the pressure ulcers yet. On November 3, 2021, at 2:25 p.m. RN-B assessed R5's heels. RN-B stated, "This is bigger than when I saw it last week. It's way worse than I thought it was." RN-B stated she	0 430		

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0 430	Continued From page 10 would have assumed orders were obtained for R5's pressure ulcers and felt that the open wound should have a dressing on it. RN-B measured R5's wounds and noted R5 was exhibiting facial grimacing while taking measurements. R5's left heel pressure ulcer measured 2.3 centimeters (cm) x 2.9 cm. R5's right heel pressure ulcer measured 4.5 cm x 5.3 cm, with the open area of the pressure ulcer measuring 2.7 cm x 2.3 cm. RN-B confirmed staff had not been dressing the open wound and had not initiated any kind of dressing or wound care while waiting for home care to assess. On November 3, 2021, at 2:35 p.m. LPN-C stated since the facility doesn't always have a nurse on site and due to the cost of wound care supplies, they did not do wound care services. LPN-C stated the home care agency was contacted on October 26, 2021, to provide wound care services for R5, and verified the licensee did not implement any type of dressing or wound care for the pressure ulcers while waiting for the home care agency to come and assess. According to the UDALSA, the licensee would provide basic wound care. The home care agency assessed the resident on November 3, 2021, and wound care was initiated November 4, 2021. A policy regarding services available on the UDALSA was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 430		

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0 470	Continued From page 11	0 470		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a staffing plan to determine staffing levels to meet the needs of all residents. This had the potential to affect all residents, staff and visitors.	0 470		

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0 470	Continued From page 12 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: The licensee held an assisted living facility with dementia care license. The facility was licensed for a bed capacity of 32 residents and had a current census of 28 residents. During the entrance conference on November 2, 2021, at approximately 12:15 p.m. registered nurse (RN)-B was identified as the clinical nurse supervisor. On November 2, 2021, at approximately 12:45 p.m. licensed assisted living director (LALD)-A stated a written staffing plan had not been developed; however, the facility was staffed as follows: -RN on-site for eight hours on Tuesdays and Wednesdays and available via telephone around the clock; -licensed practical nurse (LPN) on-site seven days a week for a minimum of eight hours a day; and -five unlicensed personnel (ULP) for day shift, five ULP for evening shift, and two or three ULP for overnights. The facility's staffing schedule was reviewed and indicated most overnights had three ULP scheduled; however, some overnights had two	0 470		

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0 470	Continued From page 13 ULP scheduled. On November 3, 2021, at approximately 8:50 a.m. LALD-A stated the facility was hiring additional overnight ULP and was working with the temporary staffing agencies to secure additional ULP. LALD-A confirmed the licensee did not have a developed staffing plan to indicate when to increase or decrease staff or indicate what measures were considered with scheduling. The licensee's 4.06 Staffing & Scheduling policy dated August 1, 2021, indicated the clinical nurse supervisor would develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven days a week. The clinical nurse supervisor must ensure that staffing levels were adequate to address the following: a. Each resident's needs, as identified in the resident's service plan and assisted living contract; b. each resident's acuity level, as determined by the most recent assessment or individualized review; c. The ability of staff to timely meet the residents' scheduled and reasonably foreseeable unscheduled needs given the physical layout of the facility premises; d. Whether the facility has a secured dementia care unit; and e. Staff experience, training, and competency. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		

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0 480	Continued From page 14	0 480		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated November 2, 2021, for the specific Minnesota Food Code deficiencies.	0 480		

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0 480	Continued From page 15 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to COVID-19, when they did not comply with MDH guidance for COVID-19 related to wearing appropriate PPE (personal protective equipment). This had the potential to affect all 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), 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	0 510		

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0 510	Continued From page 16 of the residents). The findings include: On November 2, 2021, at approximately 3:40 p.m. a shelving unit was observed near the entrance to the facility. The shelving unit contained bins labeled with staff members' names and contained brown paper bags for surgical masks to be stored. On November 3, 2021, at approximately 6:30 a.m. unlicensed personnel (ULP)-F stated she and ULP-K worked the overnight shift. Both ULP-F and ULP-K were observed not to be wearing eye protection. On November 3, 2021, at approximately 6:40 a.m. ULP-I was observed to be wearing her mask pulled down below her nose and was not wearing eye protection while providing direct care to the licensee's residents. ULP-I was observed to perform various tasks over the course of approximately one hour with her mask pulled down below her nose. On November 3, 2021, at approximately 12:35 p.m. licensed assisted living director (LALD)-A stated they encouraged staff to re-use surgical masks for up to five days and the masks were stored in the brown paper bags corresponding with the staff member's name. LALD-A stated if a mask is soiled, staff can replace it but confirmed that many staff members are still reusing surgical masks for several days before obtaining a new one. Centers for Disease Control guidance dated September 10, 2021, indicated when masks are used for source control for health care workers,	0 510		

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0 510	Continued From page 17 the mask could be used for the entire shift unless it became soiled, damaged, or hard to breathe through. The guidance indicated if masks are used during the care of patient for which a facemask is indicated for personal protective equipment, they should be removed and discarded after the patient care encounter and a new one should be donned. The guidance further directed that eye protection (goggles or a face shield that covers the front and side of the face) should be worn during all patient care encounters. The licensee's 4.35 Covid policy last updated October 7, 2020, indicated the licensee had implemented the extended use of facemasks and eyewear for the duration of their entire shift for employees providing direct patient care. The policy indicated the licensee would continue to monitor and if necessary, change their policy as the recommendations from MDH and CDC guidance adapts and changes. The policy indicated the mask must always be properly placed covering your nose and mouth. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 620 SS=D	144G.42 Subd. 6 Compliance with requirements for reporting ma 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (a) The assisted living facility must comply with the requirements for the reporting of	0 620		

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0 620	Continued From page 18	0 620		

maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment and complete a thorough investigation for two of two residents (R5 and R19) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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:

The licensee failed to immediately report to MAARC pressure ulcer development for R5 and elopement for R19.

R5
R5 was observed on November 3, 2021, at 2:25 p.m. to have unstageable bilateral pressure ulcers to heels.

R5's diagnoses included, but were not limited to, Alzheimer's disease, anxiety disorder, and muscle weakness.

R5's Service Plan dated July 29, 2021, indicated the resident required assistance with dressing,

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0 620	Continued From page 19 feeding, oral hygiene, hair care, grooming, toileting, weekly laundry and housekeeping, and a three times daily "I'm OK" check. An incident report from September 19, 2021, indicated R5 obtained a skin tear to the right hand after an unwitnessed fall. The root cause analysis (RCA) included impaired memory, confused, self-transferring/ambulating with a four wheeled walker, wanderer, lack of safety awareness, recent medication changes. Intervention: does have motion sensor in bedroom, safety checks every two hours, rounding provider to assess medication regimen effectiveness on September 21, 2021. An incident report from October 1, 2021, indicated R5 sustained a right hip fracture after a witnessed fall. No new interventions were implemented after the fall on October 1, 2021. A Uniform Assessment Tool dated October 5, 2021, indicated R5's transfer status changed to an EZ stand and required an assist of two for ambulation, bed mobility, and transfers. The assessment did not indicate any risk factors or skin issues were present at that time. Progress notes indicated R5 had a follow up orthopedic appointment on October 21, 2021, where R5 was downgraded to 50% weight bearing on the right hip. Progress notes indicated the resident's walking program was discontinued on October 26, 2021, pending further clarification from orthopedics. R5's task documentation from October 24, 2021, through October 31, 2021, showed the following documentation for staff monitoring every two hours:	0 620		

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0 620	Continued From page 20 -On October 24, 2021, nine of 12 opportunities for turning/repositioning were missed. There was no documentation of repositioning between 5:12 a.m. and 4:13 p.m. -On October 25, 2021, 10 of 12 opportunities for turning/repositioning were missed. R5 was turned/repositioned at 4:10 a.m. and 12:47 p.m., no further documentation was entered that day. -On October 26, 2021, 11 of 12 opportunities for turning/repositioning were missed. R5 was turned at 4:40 p.m., no further documentation for turning/repositioning was entered that day. -On October 27, 2021, 11 of 12 opportunities for turning/repositioning were missed. R5 was turned at 4:14 p.m., no further documentation for turning/repositioning was entered that day. -On October 28, 2021, 12 of 12 opportunities for turning/repositioning were missed. R5 did not have documentation for turning/repositioning entered that day. -On October 29, 2021, eight of 12 opportunities for turning/repositioning were missed. R5 went nine hours between turning from 2:01 p.m. to 9:28 p.m. -On October 30, 2021, eight of 12 opportunities for turning/repositioning were missed. R5's last documented turning and repositioning for the day was at 1:00 p.m. -On October 31, 2021, 11 of 12 opportunities for turning/repositioning were missed. R5 was turned at 1:13 a.m., no further documentation for turning/repositioning was entered that day. A progress note completed by LPN-B dated October 27, 2021, indicated R5 had stage one pressure ulcers to both heels. No further notes were entered after this date and measurements were not obtained. The note indicated home health wound care was to evaluate and treat.	0 620		

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0 620	Continued From page 21 A clinical communication tool dated October 28, 2021, indicated the resident was to be turned and repositioned every 1.5 to 2 hours. On November 3, 2021, at approximately 12:00 p.m. registered nurse (RN)-B stated R5 had unstageable, intact pressure ulcers to both heels and a contracted home health agency was managing wound care for R5. RN-B confirmed no measurements had been taken and no documentation was done after October 27, 2021, because the licensee did not manage wound care, and a referral had been made to a home care provider for wound care. On November 3, 2021, at 12:30 p.m. RN-B stated she was told "we try to stay away from nursing care" by LPN-C "so we try not to do nursing stuff and have home care do it instead." RN-B stated since she was only onsite two days a week, she had not had a chance to assess the wound this week. RN-B was not aware the right heel wound had opened, and was not sure if the home care agency had been able to assess the pressure ulcers. On November 3, 2021, at approximately 12:40 p.m. RN-B stated she would expect staff to be turning and repositioning R5 at least every two hours due to noted skin breakdown and decrease in mobility. RN-B was unsure how often R5 had been turned and repositioned in the days leading up to the resident developing pressure ulcers to both heels. RN-B confirmed the documentation entered for the resident's tasks were not completed in a timely manner and did not reflect the actual times services were performed. On November 3, 2021, at 2:25 p.m. RN-B assessed R5's heels. RN-B stated, "This is	0 620		

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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
0 620	Continued From page 22 bigger than when I saw it last week. It's way worse than I thought it was." RN-B stated she would have assumed orders were obtained for R5's pressure ulcers and felt that the open wound should have a dressing on it right now. RN-B measured R5's wounds and noted R5 was exhibiting facial grimacing while taking measurements. R5's left heel pressure ulcer measured 2.3 centimeters (cm) x 2.9 cm. R5's right heel pressure ulcer measured 4.5 cm x 5.3 cm, with the open area of the pressure ulcer measuring 2.7 cm x 2.3 cm. RN-B confirmed staff had not been dressing the open wound and had not initiated any kind of dressing or wound care while waiting for home care to assess. The home care agency assessed the resident on November 3, 2021, and wound care was initiated November 4, 2021. On November 4, 2021, at approximately 10:30 a.m. LPN-C stated that RN-B was not aware of the worsening pressure ulcers until "Tuesday" (November 2, 2021) afternoon as it was their procedure to notify the RN within 24 hours if the issue was not emergent; however, in an earlier interview with RN-B on November 3, 2021, RN-B indicated she had not been notified of the worsening pressure ulcer and was not aware of the change of condition until updated by the surveyor. On November 4, 2021, at approximately 10:45 a.m. unlicensed personnel (ULP)-I stated she noticed R5's pressure ulcer opened "late Saturday night" (October 30, 2021) "into early Sunday morning" (October 31, 2021). ULP-I stated she believed the RN was notified, but was not sure. ULP-I stated she notified the LPN on "Monday" (November 1, 2021) about the	0 620		

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0 620	Continued From page 23	0 620		

worsening pressure ulcer. ULP-I wasn't sure if that was something the RN should be immediately notified of. If they had to report an urgent issue, they would usually call the on call number; otherwise, they would talk to the nurse when they came in. ULP-I was not sure if the on call nurse was a RN.

On November 4, 2021, at approximately 10:45 a.m. LPN-J stated she, LPN-C and LALD-A discussed the worsening pressure ulcers, but felt since the care plan was being followed and the family was aware of the pressure ulcers, they did not feel it was reportable. LPN-J confirmed RN-B was not involved in this decision making process or that it was determined to be not reportable. LPN-J confirmed RN-B was not updated on the worsening pressure ulcers until the afternoon of Tuesday, November 2, 2021; however, in a subsequent interview with RN-B on November 3, 2021, RN-B indicated she had not been notified of the worsening pressure ulcer and was not aware of the change of condition until updated by the surveyor. The resident's chart lacked evidence the provider and home care was notified of the worsening pressure ulcer.

R19
R19's diagnoses included, but were not limited to, dementia, muscle weakness, depression, and restless leg syndrome.

R19's service plan dated July 20, 2021, indicated the resident required assistance with dressing, oral hygiene, hair care, grooming, toileting, bathing, medication administration, weekly laundry and housekeeping and three times daily "I'm OK" checks.

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0 620	Continued From page 24 R19's record included an incident report for elopement on August 9, 2021, at 10:00 a.m. The incident report indicated R19 was confused, forgetful and anxious. The report indicated R19 had a wanderguard on at the time of the elopement, during which R19 was found in a car in the west parking lot. At the time of the incident, R19 was not residing in the memory care unit. The incident report noted LALD-A had checked R19's wanderguard on August 7, 2021, and it was functional at that time. R19's individual abuse prevention plan, undated, noted R19 had a diagnosis of dementia and required staff to monitor for safety; was unable to summons for assistance due lack of understanding of call light and had safety checks every two hours and a motion sensor alarm in her apartment; and was at risk for elopement with multiple elopement attempts which resulted in memory care placement. R19's record lacked documentation of the incident. R19's record included a uniform assessment tool dated September 1, 2021, which indicated R19 was at a high risk for elopement. On November 4, 2021, at 10:50 a.m. RN-B stated R19 was not residing in the locked unit at the time of the elopement, and had a wanderguard on at the time; however, the wanderguard had failed. RN-B stated "it was a bad scenario" and R19 was moved to the locked memory care unit on September 1, 2021. RN-B confirmed a MAARC report was not made, and stated she did not feel a report was necessary since R19 had not been injured, and interventions such as the wanderguard, were in place.	0 620		

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0 620	Continued From page 25 On November 4, 2021, at 10:55 a.m. LALD-A confirmed she had been made aware of the incident and a MAARC report had not been filed. LALD-A stated the decision to report or not report was made by using the Care Provider's diagram for vulnerable adult reporting. LALD-A stated "I suppose thinking about it now, it should have been reported." The licensee's 2.44 Vulnerable Adult Maltreatment - Prevention & Reporting policy dated August 1, 2021, noted staff who suspect maltreatment of a resident (abuse, financial exploitation, or neglect) or who has knowledge that a resident has sustained a physical injury which is not reasonably explained will: a. Take immediate action to protect, or keep safe, the resident affected; b. Call 911 if emergency assistance is needed; c. Contact the Clinical Nurse Supervisor if medical attention is needed; d. Contact the Assisted Living Director; e. The Assisted Living Director or Clinical Nurse Supervisor will determine how to best protect other residents from similar maltreatment in the immediate future; f. If the Assisted Living Director or Clinical Nurse Supervisor confirms the suspicion of maltreatment, they will contact MAARC. Such report must be made no later than 24 hours after the maltreatment was first suspected. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		

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0 650	Continued From page 26	0 650		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee file included all required content for one of three employees (registered nurse (RN)-B).	0 650		

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0 650	Continued From page 27 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: RN-B's employee record lacked evidence of orientation to the following requirements as part of the orientation to assisted living: -overview of assisted living statutes; and -review of the provider's policies and procedures. During an interview on November 3, 2021, at approximately 12:45 p.m. RN-B confirmed she had received orientation to the assisted living statues and the policies and procedures; however, the orientation was not documented in her employee file. The licensee's 4.05 Employee Records policy dated August 1, 2021, indicated each employee record would include: records of all training and in-service education required and/or provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control	0 660		

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0 660	Continued From page 28 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 ensure the provider established and maintained a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) current screening for active or latent TB for one of three employees (registered nurse (RN)-B). In addition, the licensee failed to ensure TB training was completed for one of three employees (RN-B) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: The facility's TB risk assessment was completed May 6, 2021, and was determined to be a low risk	0 660		

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0 660	Continued From page 29 level. SCREEN FOR ACTIVE/LATENT TB RN-B's employee record lacked documentation of a two-step screening for active/latent TB. RN-B's record included documentation of a negative Tuberculin skin test (TST) completed on October 23, 2019, and November 14, 2019; however, RN-B was hired on July 14, 2021, to provide direct care to residents and oversee licensed and unlicensed personnel at the facility. On November 3, 2021, at 12:45 p.m. RN-B confirmed she had not completed screening for active/latent TB within 90 days of hire. TB TRAINING RN-B's employee record lacked documentation of completion of training related to TB. On November 3, 2021, at 12:45 p.m. RN-B confirmed she had not completed TB training. The licensee's 8.16 Tuberculosis Screening policy dated August 1, 2021, noted staff working in the same air space of the residents would be screened and tested for tuberculosis prior to the staff being exposed to residents. Staff screening would include an IGRA (interferon gamma release assay) blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs (health care workers). In addition, the policy noted staff would be educated regarding to TB at the time of hire. Content of the training would focus on basic information about: 1. TB pathogenesis and transmission, 2. Signs and symptoms of active TB disease, and 3. the facility's infection control plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		

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0 900	Continued From page 30	0 900		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed.	0 900		

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0 900	Continued From page 31 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan section of the contract did not include limitations of provider liability. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The service plan used by the licensee for all residents contained the following language: "I understand that in case of a fall or elopement Alex Assisted Living, LLC will not be held responsible." On November 3, 2021, at approximately 12:35 p.m. licensed assisted living director (LALD)-A stated that language was probably part of an older contract. The licensee's 6.08 Service Plan policy did not address limitations of provider liability. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		

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0 970	Continued From page 32	0 970		
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 interview and record review, the facility failed to ensure the contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On November 2, 2021, at approximately 2:00 p.m. a copy of the facility's contract was requested. The contract included two clauses that indicated the resident would waive the facility's liability for health, safety, or personal property of a resident. Page 15, section 2. of the contract indicated a	0 970		

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0 970	Continued From page 33 resident would indemnify or hold harmless the provider, its employees and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by resident of the rented premises or any other part of the provider's property, or caused wholly or in part by an act or omission of resident or resident's guests or agents. Page 15 section 4. of the contract indicated the provider was not liable to resident or resident's guests for any injury, death or property damage occurring in the apartment unit or on provider's premises unless such injury, death or property damage occurred as a result of an equipment malfunction or hazardous conditions within the building not caused by the resident or resident's guests. On November 2, 2021, at approximately 3:15 p.m. licensed assisted living director (LALD)-A confirmed the contract required residents to waive the facility's liability for health, safety, or personal property. LALD-A confirmed the same contract was used for all residents at the facility. A policy on content of assisted living contracts was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01350 SS=D	144G.60 Subd. 5 Temporary staff When a facility contracts with a temporary staffing agency, those individuals must meet the same requirements required by this section for	01350		

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01350	Continued From page 34 personnel employed by the facility and shall be treated as if they are staff of the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure contracted staff met all requirements required for personnel employed by the facility for one of one unlicensed personnel (ULP-H) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: During the entrance conference on November 2, 2021, at approximately 12:45 p.m. licensed assisted living director (LALD)-A confirmed the licensee was utilizing two contracted ULP to maintain staffing for the facility. ULP-H was contracted on September 17, 2021, to provide direct care services to the licensee's residents. ULP-H's employee file lacked evidence of the following required content of orientation to assisted living: -overview of assisted living statutes; -review of the provider's policies and procedures; -assisted living bill of rights; -handling of resident complaints, reporting of complaints, and where to report; and -principles of person-centered planning and service delivery.	01350		

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01350	Continued From page 35 ULP-H's employee file lacked evidence of receiving eight hours of dementia related training to include the following required content: -an explanation of Alzheimer's disease and other dementias; -assistance with activities of daily living; -problem solving with challenging behaviors; -communication skills; and -person-centered planning and service delivery. ULP-H's employee file included a checklist titled CNA Skills Evaluation - Self Assessment dated January 6, 2021, which included the following statement "place a check next to the item you feel comfortable and proficient in and have performed the skill within the last year and would not require supervision or practice to perform." ULP-H's employee filed lacked evidence of being current on the Minnesota registry of nursing assistants. The checklist did not indicate ULP-H had been trained and was competent in the following areas: -documentation requirements for all services provided; -appropriate and safe techniques in personal hygiene and grooming to include: hair care and bathing, care of teeth, gums, and oral prosthetic devices, care and use of hearing aids and dressing and assisting with toileting; -training on the prevention of falls for providers working with the elderly or individuals at risk of falls; -standby assistance techniques and how to perform them; -medication, exercise and treatment reminders; -basic nutrition, meal preparation, food safety and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -communication skills that include preserving the	01350		

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01350	Continued From page 36 dignity of the resident and showing respect for the resident and the resident's preferences, cultural background and family; -understanding appropriate boundaries between staff and residents and the resident's family; -awareness of commonly used health technology equipment and assistive devices; -observing, reporting, and documenting of resident status; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed that must be reported to appropriate personnel; -reading and recording temperature, pulse, and respirations of the resident; -recognizing physical, emotional, cognitive, and developmental needs of the resident; -safe transfer techniques and ambulation; -range of motioning and positioning; -administering medications or treatments as required; and -other registered nurse (RN) delegated tasks including but not limited to unplanned time away medications, fall alarms, catheter care, Broda chair and mechanical lifts. ULP-H's employee file lacked evidence ULP-H was supervised within 30 days of performing delegated tasks, as required. On November 3, 2021, at 12:45 p.m. licensed assisted living director (LALD)-A confirmed ULP-H's record lacked the above required orientation, training, and competencies. LALD-A stated she believed the CNA Skills Evaluation checklist demonstrated training and competencies completed by the temporary staffing agency. On November 4, 2021, at 10:10 a.m. RN-B	01350		

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01350	Continued From page 37 confirmed she had not completed a 30 day supervision of ULP-H performing delegated tasks. The licensee's 4.07 Temporary and Contracted Staff policy dated August 1, 2021, indicated temporary supplemental staffing or contracted staff will only be used if they meet the same requirements required as hired employees and will be treated as if they are staff of the facility. The licensee's 5.01 Orientation of Staff and Supervisors & Content policy dated August 1, 2021, indicated all staff of Alex Assisted Living providing and supervising direct care services must complete an orientation of Assisted Living facility licensing requirements and regulations before providing assisted living services to residents. The licensee's 5.02 Competency Training Evaluations policy dated August 1, 2021, indicated when a registered nurse (RN) of Alex Assisted Living delegated tasks, prior to the delegation of services the RN must make certain the ULP was trained in the proper methods to perform the tasks or procedures and able to demonstrate the ability to competently follow the procedures and perform the tasks. The licensee's 5.03 Dementia Training policy dated August 1, 2021, indicated direct care employees would complete eight hours of initial training within 80 hours of the employment start date, with the topics to include: an explanation of Alzheimer's disease and other dementias, assistance with activities of daily living, problem solving with challenging behaviors, communication skills and person centered planning and service delivery.	01350		

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01350	Continued From page 38 The licensee's 4.35 Employee Evaluation policy dated August 1, 2021, indicated all staff would be given an employee evaluation at least annually; however, the policy did not address supervision of delegated tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01350		
01390 SS=F	144G.62 Subdivision 1 Availability of contact person to staff (a) Assisted living facilities must have a registered nurse available for consultation by staff performing delegated nursing tasks and must have an appropriate licensed health professional available if performing other delegated services such as therapies. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to have a registered nurse available for consultation by staff performing delegated nursing tasks. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	01390		

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01390	Continued From page 39 The findings inlude: On November 2, 2021, at approximately 12:15 p.m. licensed assisted living director (LALD)-A confirmed the facility had a registered nurse (RN) on call 24 hours a day, seven days a week. R5 R5 was observed on November 3, 2021, at 2:25 p.m. to have unstageable bilateral pressure ulcers to heels. R5's diagnoses included, but were not limited to, Alzheimer's disease, anxiety disorder, and muscle weakness. R5's service plan dated July 29, 2021, indicated the resident required assistance with dressing, feeding, oral hygiene, hair care, grooming, toileting, weekly laundry and housekeeping, and a three times daily "I'm OK" check. An incident report from September 19, 2021, indicated R5 obtained a skin tear to the right hand after an unwitnessed fall. The root cause analysis (RCA) included impaired memory, confused, self-transferring/ambulating with a four wheeled walker, wanderer, lack of safety awareness, recent medication changes. Intervention: does have motion sensor in bedroom, safety checks every two hours, rounding provider to assess medication regimen effectiveness on September 21, 2021. An incident report from October 1, 2021, indicated R5 sustained a right hip fracture after a witnessed fall. No new interventions were implemented after the fall on October 1, 2021. A progress note completed by LPN-B dated	01390		

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01390	Continued From page 40 October 27, 2021, indicated R5 had stage one pressure ulcers to both heels. No further notes were entered after this date and measurements were not obtained. The note indicated home health wound care was to evaluate and treat. On November 3, 2021, at approximately 12:00 p.m. registered nurse (RN)-B stated R5 had unstageable, intact pressure ulcers to both heels and a contracted home health agency was managing wound care for R5. RN-B confirmed no measurements had been taken and no documentation was done after October 27, 2021, because the licensee did not manage wound care and they had made a referral to a home care provider to manage the wounds. On November 3, 2021, at 12:30 p.m. RN-B stated she was told "we try to stay away from nursing care" by licensed practical nurse (LPN)-C "so we try not to do nursing stuff and have home care do it instead." RN-B stated since she was only onsite two days a week, she had not had a chance to assess the wound this week, was not aware it had opened up and was not sure if the home care agency had been able to assess the pressure ulcers. On November 3, 2021, at approximately 12:35 p.m. LALD-D stated if the LPN was called, they would be the one who called the RN, if warranted. On November 3, 2021, at 2:25 p.m. RN-B assessed R5's heels. RN-B stated, "This is bigger than when I saw it last week. It's way worse than I thought it was." RN-B stated she would have assumed orders were obtained for R5's pressure ulcers and felt that the open wound	01390		

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01390	Continued From page 41 should have a dressing on it right now. RN-B measured R5's wounds and noted R5 was exhibiting facial grimacing while taking measurements. R5's left heel pressure ulcer measured 2.3 centimeters (cm) x 2.9 cm. R5's right heel pressure ulcer measured 4.5 cm x 5.3 cm, with the open area of the pressure ulcer measuring 2.7 cm x 2.3 cm. RN-B confirmed staff had not been dressing the open wound and had not initiated any kind of dressing or wound care while waiting for home care to assess. On November 4, 2021, at approximately 10:30 a.m. LPN-C stated that RN-B was not aware of the worsening pressure ulcers until Tuesday (November 2, 2021) afternoon as it was their procedure to notify the RN within 24 hours if the issue was not emergent; however, in an earlier interview with RN-B on November 3, 2021, RN-B indicated she had not been notified of the worsening pressure ulcer and was not aware of the change of condition until updated by the surveyor. On November 4, 2021, at approximately 10:45 a.m. unlicensed personnel (ULP)-I stated she noticed R5's pressure ulcer opened late Saturday night (October 30, 2021) into early Sunday morning (October 31, 2021). ULP-I stated she believed the RN was notified, but was not sure. ULP-I stated she notified the LPN on Monday (November 1, 2021) about the worsening pressure ulcer. ULP-I wasn't sure if that was something the RN should be immediately notified of. If they had to report an urgent issue, they would usually call the on call number; otherwise, they would talk to the nurse when they came in. ULP-I was not sure if the on call nurse was a RN.	01390		

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01390	Continued From page 42 The nursing schedule dated September 27, 2021, thru November 13, 2021, indicated the scheduled on-call nurse for each day was a licensed practical nurse, and not a registered nurse. The licensee's 6.12 Availability of an RN for Staff policy dated August 1, 2021, indicated a registered nurse must be available for consultation by staff performing delegated nursing tasks, must be readily available either in person, by telephone, or by other means to the staff at all times when the staff are providing services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01390		
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; (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;	01470		

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01470	Continued From page 43 (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 (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.	01470		

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01470	Continued From page 44 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all required content of orientation was provided to one of three employees (registered nurse (RN)-B). 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: RN-B's employee record lacked evidence RN-B had received orientation to principles of person-centered planning and service delivery. RN-B was hired August 1, 2021, to provide direct care to residents and supervise unlicensed personnel. On November 2, 2021, at 12:45 p.m. RN-B confirmed she had not received orientation to the above required contents. The licensee's 5.01 Orientation of Staff and Supervisors & Content policy dated August 1, 2021, noted orientation must be completed once for each staff person and must include: 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	01470		
01490 SS=D	144G.63 Subd. 4 Training required relating to dementia	01490		

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01490	Continued From page 45 All direct care staff and supervisors providing direct services must demonstrate an understanding of the training specified in section 144G.64. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all staff received dementia care as required for two of two employees (registered nurse (RN)-B, 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 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: RN-B RN-B was hired on August 1, 2021, to provide direct care services to residents and supervision of ULP at the facility. RN-B's employee record indicated RN-B completed one hour of dementia training in a course titled Dementia 1- Introduction and Overview, completed August 24, 2021; however, RN-B's record lacked documentation of completion of eight hours of initial training within 120 working hours of first day of employment that included: -an explanation of Alzheimer's disease and other dementias; -assistance with activities of daily living; -problem solving with challenging behaviors;	01490		

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01490	Continued From page 46 -communication skills; and -person-centered planning and service delivery. On November 3, 2021, at 12:45 p.m. RN-B confirmed she had not completed dementia training, as required. ULP-G ULP G was hired on August 1, 2021, to provide direct care and services to residents. ULP-G's employee record indicated ULP-G completed three hours of dementia training in courses titled Dementia-Activities-Chores, Working, and Volunteering, Dementia-Activities-Hydration, Nutrition, Eating, and Dining, and Dementia-Person-centered Care, completed June 11, 2021, and September 23, 2021, respectively. ULP-G's record lacked documentation of completion of eight hours of initial training within 80 working hours of the first day of employment that included: -an explanation of Alzheimer's disease and other dementias; -assistance with activities of daily living; -problem solving with challenging behaviors; and -communication skills On November 3, 2021, at 12:40 p.m. licensed assisted living director (LALD)-A confirmed RN-B and ULP-G lacked documentation of completion of dementia training as required. The licensee's 3.08 ALDC Notice of Dementia Training dated August 1, 2021, noted supervisors of direct care staff would have eight hours of initial training within 120 hours of first day of employment and direct care staff would have eight hours of initial training within 80 hours of first day of employment. The training topics were the same for both supervisors of direct care staff	01490		

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01490	Continued From page 47 and direct care staff, and would include: -an explanation of Alzheimer's disease and other dementias; -assistance with activities of daily living; -problem solving with challenging behaviors; -communication skills; and -person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	01490		
01700 SS=E	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to	01700		

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01700	Continued From page 48 manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) had assessed three of three residents (R1, R2, R3) prior to initiating medication management services with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R1, R2 and R3's records lacked evidence a medication assessment by a RN was completed to include all required content prior to initiating medication management services. R1 R1's diagnoses included, but were not limited to, dementia and stage three chronic kidney disease. R1's service plan dated July 26, 2021, indicated the resident received medication management services.	01700		

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01700	Continued From page 49 R1's prescriber orders dated January 2021, included, but were not limited to, a stool softner and a medication for mood. On November 3, 2021, at approximately 8:00 a.m. unlicensed personnel (ULP)-G was observed to administer medications to R1. R1's Uniform Assessment Tool dated September 22, 2021, indicated R1 required medication administration; however, the assessment lacked the following required content: -identification and review of all medications the resident was known to be taking; and -actions to address medication side effects, contraindications, allergic or adverse reactions. R2 R2's diagnoses included, but were not limited to, Alzheimer's disease, vascular dementia with behavioral disturbance, unspecified dementia without behavioral disturbance, type II diabetes, anxiety, and cerebral infarction (stroke). R2's service plan dated July 20, 2021, indicated the resident received medication management services. R2's prescriber orders dated January 18, 2021, included, but were not limited to, one antidepressant, insulin, one cholesterol medication, one calcium channel blocker, one blood thinner, and one antipsychotic. On November 3, 2021, at approximately 8:30 a.m. ULP-G was observed to administer R2's scheduled morning medications. R2's Uniform Assessment Tool dated October 6, 2021, indicated R2 required medication	01700		

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01700	Continued From page 50	01700		

administration; however, the assessment lacked the following required content:
-identification and review of all medications the resident was known to be taking; and
-actions to address medication side effects, contraindications, allergic or adverse reactions.

R3
R3's diagnoses included but were not limited to, tinea pedis (fungus on the feet), acute respiratory failure, heart disease, and cerebral infarction (stroke).

R3's service plan dated July 14, 2021, indicated R3 received medication management services to include medication administration.

On November 3, 2021, at approximately 8:15 a.m. ULP-E was observed to administer R3's scheduled morning medications.

R3's Uniform Assessment Tool dated September 8, 2021, indicated R3 required medication administration; however, the assessment lacked the following required content:
-identification and review of all medications the resident was known to be taking; and
-actions to address medication side effects, contraindications, allergic or adverse reactions.

On November 3, 2021, at approximately 12:00 p.m. RN-B confirmed the assessments for R1, R2, and R3 lacked all required content as noted above.

The licensee's 7.01 Medication Management - Assessment, Monitoring & Reassessment policy dated August 1, 2021, indicated prior to providing medication management services, the RN will

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01700	Continued From page 51 conduct an assessment face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking, review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions and actions to address these issues. The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications, and the resident will be monitored and reassessed as need when the resident presents with symptoms or other issues that may be medications-related and, at a minimum, annually. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01730 SS=E	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:	01730		

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01730	Continued From page 52 (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for three of three residents (R1, R2, R3) with records reviewed.	01730		

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01730	Continued From page 53 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: During the entrance conference on November 2, 2021, at approximately 12:30 p.m. licensed assisted living director (LALD)-A and registered nurse (RN)-B confirmed the licensee provided medication management services to the residents in the facility. R1 R1's diagnoses included, but were not limited to, dementia and stage three chronic kidney disease. R1's service plan dated July 26, 2021, indicated the resident received medication management services. R1's prescriber orders dated January 2021, included, but were not limited to, a stool softner and a medication for mood. On November 3, 2021, at approximately 8:00 a.m. ULP-G was observed to administer medications to R1. R1's medication management record did not include the following: -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; -identification of medication management tasks that may be delegated to ULP; -procedures for staff notifying a RN or appropriate	01730		

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licensed health professional when a problem arises with medication management services;
-any resident-specific requirements relating to documenting medication administration, verification that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions; and
-completion of medication reconciliation.

R2
R2's diagnoses included, but were not limited to, Alzheimer's disease, vascular dementia with behavioral disturbance, unspecified dementia without behavioral disturbance, type II diabetes, anxiety, and cerebral infarction (stroke).
R2's service plan dated July 20, 2021, indicated the resident received medication management services.
R2's prescriber orders dated January 18, 2021, included, but were not limited to, one antidepressant, insulin, one cholesterol medication, one calcium channel blocker, one blood thinner, and one antipsychotic.
On November 3, 2021, at approximately 8:30 a.m. ULP-G was observed to administer R2's scheduled morning medications.
R2's medication management record did not include the following:
-identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;
-identification of medication management tasks that may be delegated to ULP;
-procedures for staff notifying a RN or appropriate licensed health professional when a problem arises with medication management services;
-any resident-specific requirements relating to documenting medication administration, verification that all medications are administered

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as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions; and
-completion of medication reconciliation.
On November 3, 2021, at approximately 12:00 p.m. RN-B confirmed R1 and R2's record lacked all required content noted above.

R3
R3's diagnoses included but were not limited to, tinea pedis (fungus on the feet), acute respiratory failure, heart disease, and cerebral infarction (stroke).

R3's service plan dated July 14, 2021, indicated R3 received medication management services to include medication administration.

R3's prescriber orders dated July 14, 2021, included but were not limited to, one mild analgesic, one inhaler, two blood thinners, five supplements, one medication for urinary retention, and one anti-diarrheal.

On November 3, 2021, at approximately 8:15 a.m. ULP-E was observed to administer R3's scheduled morning medications.

R3's medication management record did not include the following:
-identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;
-identification of medication management tasks that may be delegated to ULP;
-procedures for staff notifying a RN or appropriate licensed health professional when a problem arises with medication management services;
-any resident-specific requirements relating to documenting medication administration;

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01730	Continued From page 56 verification that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions; and -completion of medication reconciliation. On November 3, 2021, at approximately 12:00 p.m., RN-B confirmed the R3's record lacked all required content noted above. The licensee's 7.03 Medication Management Individualized Plan policy dated August 1, 2021, indicated a medication management record would be developed and maintained for each resident and would include 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 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. No further information was provided.	01730		

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01730	Continued From page 57 TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be	01790		

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01790	Continued From page 58 labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. 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	01790		

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01790	Continued From page 59	01790		

is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:

During the entrance conference on November 2, 2021, at approximately 12:30 p.m. licensed assisted living director (LALD)-A, registered nurse (RN)-B and licensed practical nurse (LPN)-C confirmed the licensee provided medication management services to all residents. LPN-C confirmed she was responsible for setting up medications for planned time away, and unlicensed personnel (ULP) would occasionally set up medications for unplanned time away; however, there was typically a licensed nurse available to assist.

The licensee failed to develop and implement a written procedures for the ULP providing medications for residents having unplanned times away.

On November 4, 2021, at 10:10 a.m. RN-B confirmed she had not developed a procedure for unplanned time away medications, and was unsure what the process currently was.

The licensee's 7.10 Medication Management - Planned & Unplanned Time Away policy dated August 1, 2021, indicated for unplanned time away, when the pharmacy or licensed nurse was not available to provide the medications, the registered nurse may delegate the task to properly trained and competency tested ULP, who may give the resident or resident's representative medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days. The

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01790	Continued From page 60 policy further indicated the registered nurse would develop written procedures for the ULP, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: a. the type of container or containers to be used for the medications appropriate to the providers's medication system; b. how the container or containers must be labeled; c. the written information about the medications to be given to the resident or the resident's representative; d. how the ULP staff must documents in the resident's record that medications have been given to the resident or the resident's representative, including documenting the date the medications were given to the resident or the resident's representative and who received the medications, the person who gave the medications to the resident, the number of medications that were given to the resident and other required information; e. how the RN shall be notified that medications have been provided and whether the RN needs to be contacted before the medications are given to the resident or the designated representative; f. a review by the RN of the completion of this task to verify this task was completed accurately by the ULP; and g. how the ULP must document in the resident's record any unused medications that are returned to the provider, including the name of each medication and the doses of each returned medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		

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01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all 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 medications were stored according to manufacturer's instructions for one of one medication refrigerator. 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: During the entrance conference on November 2, 2021, at 12:15 p.m. licensed practical nurse (LPN)-C stated the licensee provided medication management services to all residents residing at the facility. MEDICATION REFRIGERATOR MONITORING The licensee failed to monitor the single medication refrigerator to ensure medications were stored according to manufacturer's instructions.	01880		

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01880	Continued From page 62 On November 2, 2021, at approximately 12:55 p.m. the medication refrigerator was observed with LPN-C. LPN-C confirmed the temperature of the refrigerator was not monitored and the refrigerator lacked a thermometer. The refrigerator contained: -two open bottles of amoxicillin suspension (antibiotic) 250 milligram (mg)/5 milliliter (ml); -five open bottles, one unopened bottle, and 41 pre-drawn syringes of gabapentin suspension (used as an anticonvulsant or nerve pain reducer) 250 mg/5 ml; -one open bottle of omeprazole suspension (acid reducing medication) 2 mg/ml; -two unopened Victoza pen (antidiabetic medication; a multiple dose pen shaped injector device used for diabetic medication administration); and -one opened bottle and 16 pre-drawn syringes of lorazepam concentrate (antianxiety) 2 mg/ml. The manufacturer's instructions for amoxicillin suspension dated October 11, 2021, indicated to store amoxicillin suspension in a refrigerator. Do not freeze. The manufacturer's instructions for gabapentin suspension dated April 2012, indicated to store gabapentin suspension in the refrigerator (36-46 degrees Fahrenheit/F). The manufacturer's instructions for omeprazole suspension dated October 11, 2021, indicated to store omeprazole suspension in a refrigerator. Do not freeze. The manufacturer's instructions for Victoza dated December 2020, indicated before opening store Victoza pens in the refrigerator (36-46 degrees	01880		

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01880	Continued From page 63 F). Do not allow Victoza to freeze. The manufacturer's instructions for lorazepam concentrate dated October 11, 2021, indicated store lorazepam concentrate in the refrigerator (36-46 degrees F). The licensee's 7.11 Medication Storage policy dated August 1, 2021, noted medications would be stored per manufacturer's directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were maintained with the open date and the expiration date for time sensitive medications for six of six residents (R2, R3, R7, R11, R12 and R13). 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	01890		

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ALEX ASSISTED LIVING LLC	90 EAST LAKE COWDRY ROAD NW ALEXANDRIA, MN 56308

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01890	Continued From page 64 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on November 2, 2021, at 12:15 p.m. licensed practical nurse (LPN)-C stated the licensee provided medication management services to all residents residing at the facility. A facility tour was conducted on November 2, 2021, at approximately 1:00 p.m. with licensed assisted living director (LALD)-A, including a review of the locked west medication cart. The following was observed, and confirmed with licensed practical nurse (LPN)-J: R2 R2's Victoza (reduces blood sugars) lacked a label which indicated the date the pen was taken out of the refrigerator or opened. R3 R3's albuterol (opens the airways for ease of breathing) 108 mcg (microgram) inhaler lacked a label which indicated the date the inhaler had been opened and when the inhaler would expire. R7 R7's albuterol 108 mcg inhaler lacked a label which indicated the date the inhaler had been opened and when the inhaler would expire. R11 R11's Refresh eye (moistens dry eyes) drops lacked a label which indicated the date the eye drops had been opened and when the eye drops	01890		

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01890	Continued From page 65 would expire. R12 R12's Systane eye (moistens dry eyes) drops lacked a label which indicated the date the eye drops had been opened and when the eye drops would expire. R13 R13's latanoprost (treats glaucoma) 0.05% eye drops lacked a label which indicated the date the eye drops had been opened and when the eye drops would expire. The manufacturer's instructions for Victoza dated January 2010, instructed to dispose the pen 30 days after initial use. The manufacturer's instructions for albuterol inhalers dated February 2019, instructed to dispose to albuterol inhalers 12 months after opening foil pouch. The manufacturer's instructions for Refresh eye drops dated March, 2018, instructed to discard 90 days after opening. The manufacturer's instructions for Systane eye drops dated April 2017, instructed to discard one month after opening. The manufacturer's instructions for latanoprost eye drops dated November 2021, instructed once a bottle is opened for use, to discard after six weeks. The licensee's 7.11 Medication Storage policy dated August 1, 2021, noted medications would be stored consistent with manufacturer's recommendations.	01890		

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01890	Continued From page 66 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.	01940		

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01940	Continued From page 67 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain documentation of treatment administration for two of two residents (R1 and R3) who received treatments. 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: During the entrance conference on November 2, 2021, at approximately 12:30 p.m. licensed assisted living director (LALD)-A and registered nurse (RN)-B confirmed the licensee provided treatment and therapy services to residents. R1 R1's record lacked evidence of a written statement on the resident's service plan for the services being provided to include TED (thrombo embolic deterrent) stockings (provide compression to lower extremities to increase circulation and vascularity to prevent blood clots). R1's diagnoses included, but were not limited to, dementia and stage three chronic kidney disease. R1's Treatment Medication Record dated October 1 through October 31, 2021, indicated the resident had twice daily assistance with TED stockings. R1's prescriber orders did not contain orders for TED stockings.	01940		

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01940	Continued From page 68 R3 R3's record lacked evidence of a written statement on the resident's service plan for the services being provided to include TED stockings and foot soaks. In addition, R3's record lacked a list of treatment or therapy tasks delegated to ULP and procedures for notifying the RN when problems arose with treatments or therapies. R3's diagnoses included, but were not limited to, tinea pedis (fungus on the feet), acute respiratory failure, heart disease, and cerebral infarction (stroke). R3's Treatment Medication Record and documentation of services both dated October 1 thru 31, 2021, indicated the resident received foot soaks once a day Monday, Wednesday, Fridays and twice daily assistance with TED hose. R3's prescriber orders dated July 22, 2021, and October 19, 2021, respectively included orders for compression stockings on in the morning and off at bedtime and continue washing and drying both feet M/W/F. On November 3, 2021, at 12:00 p.m. RN-B confirmed R3's record lacked a written statement on the resident's service plan for the services being provided to include TED stockings and foot soaks. In addition, RN-B confirmed R3's record lacked a list of treatment or therapy tasks delegated to ULP and procedures for notifying the RN when problems arose with treatments or therapies. The licensee's 7.15 Medication & Treatment - Administration & Delegation policy dated August 1, 2021, indicated the service plan would include a written statement of the treatment/therapy management services that will be provided to the resident. No further information was provided.	01940		

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01940	Continued From page 69 TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed ensure up-to-date written or electronically recorded orders were maintained for one of two residents (R1) receiving treatments. 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: R1's prescriber orders did not contain orders for TED stockings. R1's record lacked evidence of a written	01970		

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01970	Continued From page 70 statement on the resident's service plan for the services being provided to include TED (thrombo embolic deterrent) stockings (provide compression to lower extremities to increase circulation and vascularity to prevent blood clots). R1's diagnoses included, but were not limited to, dementia and stage three chronic kidney disease. R1's Treatment Medication Record dated October 1 through October 31, 2021, indicated the resident had twice daily assistance with TED stockings. On November 3, 2021, at 7:50 a.m. R1 was observed to be wearing TED stockings. On November 3, 2021, at 12:00 p.m. RN-B confirmed R1's record lacked orders for TED stockings. The licensee's 7.20 Medication & Treatment orders policy dated August 1, 2021, indicated a current, written prescriber's order would be obtained for any treatment provided to a resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02090 SS=E	144G.82 Subdivision 1 General The licensee of an assisted living facility with dementia care is responsible for the care and housing of the persons with dementia and the provision of person-centered care that promotes each resident's dignity, independence, and comfort. This includes the supervision, training,	02090		

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02090	Continued From page 71 and overall conduct of the staff. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a dignified dining experience for three of three residents requiring assistance with meals (R1, R5, R20) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On November 3, 2021, at approximately 7:30 a.m. R1, R5, and R20 were observed to be seated in the dining room with clothing protectors in place. R1's service plan dated July 19, 2021, indicated the resident required assistance with dressing, feeding, oral hygiene, hair care, grooming, toileting, bathing, preparation of a modified diet, medication administration, assist of 2 or mechanical lift, weekly laundry and housekeeping, and a three times daily "I'm OK check." R1 was observed to be sitting at the dining room table with a clothing protector on from approximately 7:30 a.m. until 8:40 a.m. when a	02090		

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02090	Continued From page 72 staff member came to provide feeding assistance. R5 R5's service plan dated July 29, 2021, indicated the resident required assistance with dressing, feeding, oral hygiene, hair care, grooming, toileting, weekly laundry and housekeeping, and a three times daily "I'm OK check." R5 was observed to be sitting at the dining room table with a clothing protector on from approximately 7:30 a.m. until 8:55 a.m. when a staff member came to provide feeding assistance. R20 R20 was observed to be sitting at the dining room table with a clothing protector on from approximately 7:30 a.m. until 8:50 a.m. when a staff member came to provide feeding assistance. On November 3, 2021, at approximately 9:00 a.m. unlicensed personnel-ULP-G stated staff usually try to feed residents right away but some mornings they can't get them fed before helping other residents so they have to wait sometimes. On November 3, 2021, at approximately 12:00 p.m. registered nurse (RN)-B stated she felt it would be reasonable for a resident to wait 5 to 10 minutes to receive feeding assistance and that waiting an hour or more "was definitely a concern."	02090		

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02090	Continued From page 73 The licensee's Food Service/12.02 Dining Service policy dated August 1, 2021, indicated residents may be seated as early as five minutes prior to the starting time of a meal. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02090		
02120 SS=D	144G.83 Subdivision 1 General (a) An assisted living facility with dementia care must provide residents with dementia-trained staff who have been instructed in the person-centered care approach. All direct care staff assigned to care for residents with dementia must be specially trained to work with residents with Alzheimer's disease and other dementias. (b) Only staff trained as specified in subdivisions 2 and 3 shall be assigned to care for dementia residents. (c) Staffing levels must be sufficient to meet the scheduled and unscheduled needs of residents. Staffing levels during nighttime hours shall be based on the sleep patterns and needs of residents. (d) In an emergency situation when trained staff are not available to provide services, the facility may assign staff who have not completed the required training. The particular emergency situation must be documented and must address: (1) the nature of the emergency; (2) how long the emergency lasted; and (3) the names and positions of staff that provided coverage. This MN Requirement is not met as evidenced by:	02120		

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02120	Continued From page 74 Based on interview and record review, the licensee failed to ensure staff working in the dementia care unit were trained in person-centered care approach for one of one unlicensed personnel (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 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee failed to ensure the dementia care unit was staffed with ULP who had been instructed in the person-centered care approach. ULP-H was contracted from a temporary staffing agency on September 17, 2021, to provide direct care services to residents at the facility. ULP-H's employee record lacked evidence of completion of training in dementia care, including person-centered care approach. The licensee's staffing schedule from September 27, 2021, through November 13, 2021, indicated ULP-H was scheduled to work independently in the facility's dementia care unit on the following dates: -September 27, 2021; October 2, 2021; October 6, 2021; October 11, 2021; October 17, 2021; October 20, 2021; October 25, 2021; October 31, 2021; November 3, 2021; November 4, 2021; and November 8, 2021. All shifts were the the overnight shift from 11:00 p.m. to 7:00 a.m. On November 3, 2021, at approximately 12:45 p.m. licensed assisted living director (LALD)-A and registered nurse (RN)-B confirmed ULP-H had not completed all required dementia training,	02120		

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02120	Continued From page 75 including person-centered care approach, and ULP-H had worked in the dementia care unit. The licensee's 5.03 Dementia Training policy dated August 1, 2021, indicated employees may not provide direct care until the training was complete unless another employee who had completed the initial training was present to provide assistance. Direct care employees would complete eight hours of initial training within 80 hours of the employment start date, and would include the following topics: -an explanation of Alzheimer's disease and other dementias; -assistance with activities of daily living; -problem solving with challenging behaviors; -communication skills; and -person centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	02120		
02310 SS=G	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to a suitable and up-to-date plan, and subject to acceptable health care and medical, or nursing standards for one of one resident with pressure ulcers (R5) and two of three residents with side rails (R1 and R2),	02310		

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02310	Continued From page 76	02310		

with records reviewed. In addition, the licensee failed to ensure new interventions related to the root cause of falls were implemented for two of nine residents (R5 and R15) who had fallen.

This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).
The findings include:

PRESSURE ULCERS
R5
R5 was observed on November 3, 2021, at 2:25 p.m. to have unstageable bilateral pressure ulcers to heels.

R5's diagnoses included, but were not limited to, Alzheimer's disease, anxiety disorder, and muscle weakness.

R5's service plan dated July 29, 2021, indicated the resident required assistance with dressing, feeding, oral hygiene, hair care, grooming, toileting, weekly laundry and housekeeping, and a three times daily "I'm OK" check.

An incident report from September 19, 2021, indicated R5 obtained a skin tear to the right hand after an unwitnessed fall. The root cause analysis (RCA) included impaired memory, confused, self-transferring/ambulating with a four wheeled walker, wanderer, lack of safety awareness, recent medication changes. Intervention: does have motion sensor in

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02310	Continued From page 77 bedroom, safety checks every two hours, rounding provider to assess medication regimen effectiveness on September 21, 2021. An incident report from October 1, 2021, indicated R5 sustained a right hip fracture after a witnessed fall. No new interventions were implemented after the fall on October 1, 2021. A Uniform Assessment Tool dated October 5, 2021, indicated R5's transfer status changed to an EZ stand and required an assist of two for ambulation, bed mobility, and transfers. The assessment did not indicate any risk factors or skin issues were present at that time. Progress notes indicated R5 had a follow up orthopedic appointment on October 21, 2021, where R5 was downgraded to 50% weight bearing on the right hip. Progress notes indicated the resident's walking program was discontinued on October 26, 2021, pending further clarification from orthopedics. R5's task documentation from October 24, 2021, through October 31, 2021, showed the following documentation for staff monitoring every two hours: -On October 24, 2021, nine of 12 opportunities for turning/repositioning were missed. There was no documentation of repositioning between 5:12 a.m. and 4:13 p.m. -On October 25, 2021, 10 of 12 opportunities for turning/repositioning were missed. R5 was turned/repositioned at 4:10 a.m. and 12:47 p.m., no further documentation was entered that day. -On October 26, 2021, 11 of 12 opportunities for turning/repositioning were missed. R5 was turned at 4:40 p.m., no further documentation for turning/repositioning was entered that day.	02310		

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	30718	A. BUILDING: _____ B. WING _____	11/04/2021

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02310	Continued From page 78 -On October 27, 2021, 11 of 12 opportunities for turning/repositioning were missed. R5 was turned at 4:14 p.m., no further documentation for turning/repositioning was entered that day. -On October 28, 2021, 12 of 12 opportunities for turning/repositioning were missed. R5 did not have documentation for turning/repositioning entered that day. -On October 29, 2021, eight of 12 opportunities for turning/repositioning were missed. R5 went nine hours between turning from 2:01 p.m. to 9:28 p.m. -On October 30, 2021, eight of 12 opportunities for turning/repositioning were missed. R5's last documented turning and repositioning for the day was at 1:00 p.m. -On October 31, 2021, 11 of 12 opportunities for turning/repositioning were missed. R5 was turned at 1:13 a.m., no further documentation for turning/repositioning was entered that day. A progress note completed by licensed practical nurse (LPN)-B dated October 27, 2021, indicated R5 had stage one pressure ulcers to both heels. No further notes were entered after this date and measurements were not obtained. The note indicated home health wound care was to evaluate and treat. A clinical communication tool dated October 28, 2021, indicated the resident was to be turned and repositioned every 1.5 to 2 hours. On November 3, 2021, at approximately 12:00 p.m. registered nurse (RN)-B stated R5 had unstageable, intact pressure ulcers to both heels and a contracted home health agency was managing wound care for R5. RN-B confirmed no measurements had been taken and no documentation was done after October 27, 2021,	02310		

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because the licensee did not manage wound care and they had made a referral to a home care provider to manage the wounds.

On November 3, 2021, at 12:30 p.m. RN-B stated she was told "we try to stay away from nursing care" by LPN-C "so we try not to do nursing stuff and have home care do it instead." RN-B stated since she was only onsite two days a week, she had not had a chance to assess the wound this week, was not aware the right heel had opened up and was not sure if the home care agency had been able to assess the pressure ulcers.

On November 3, 2021, at approximately 12:40 p.m. RN-B stated she would expect staff to be turning and repositioning R5 at least every two hours due to noted skin breakdown and decrease in mobility. RN-B was unsure how often R5 had been turned and repositioned in the days leading up to the resident developing pressure ulcers to both heels. RN-B confirmed the documentation entered for the resident's tasks were not completed in a timely manner and did not reflect the actual times services were performed.

On November 3, 2021, at 2:25 p.m. RN-B assessed R5's heels. RN-B stated, "This is bigger than when I saw it last week. It's way worse than I thought it was." RN-B stated she would have assumed orders were obtained for R5's pressure ulcers and felt that the open wound should have a dressing on it. RN-B measured R5's wounds and noted R5 was exhibiting facial grimacing while taking measurements. R5's left heel pressure ulcer measured 2.3 centimeters (cm) x 2.9 cm. R5's right heel pressure ulcer measured 4.5 cm x 5.3 cm, with the open area of the pressure ulcer measuring 2.7 cm x 2.3 cm. RN-B confirmed staff had not been dressing the

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open wound and had not initiated any kind of dressing or wound care while waiting for home care to assess.

The home care agency assessed the resident on November 3, 2021, and wound care was initiated November 4, 2021.

On November 4, 2021, at approximately 10:30 a.m. LPN-C stated that RN-B was not aware of the worsening pressure ulcers until Tuesday afternoon (November 2, 2021) as it was their procedure to notify the RN within 24 hours if the issue was not emergent; however, in an earlier interview with RN-B on November 3, 2021, RN-B indicated she had not been notified of the worsening pressure ulcer and was not aware of the change of condition until updated by the surveyor.

On November 4, 2021, at approximately 10:45 a.m. unlicensed personnel (ULP)-I stated she noticed R5's pressure ulcer opened late Saturday night (October 30, 2021) into early Sunday morning (October 31, 2021). ULP-I stated she believed the RN was notified, but was not sure. ULP-I stated she notified the LPN on Monday (November 1, 2021) about the worsening pressure ulcer. ULP-I wasn't sure if that was something the RN should be immediately notified of. If they had to report an urgent issue, they would usually call the on call number; otherwise, they would talk to the nurse when they came in. ULP-I was not sure if the on call nurse was a RN.

On November 4, 2021, at approximately 10:55 a.m. LPN-J stated staff notified her of the worsening pressure ulcer on Monday morning (November 1, 2021), approximately 24 hours after the pressure ulcer opened. LPN-J

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02310	Continued From page 81 confirmed she did not immediately notify the RN since the issue was not emergent. The resident's chart lacked evidence the provider and home care was notified of the worsening pressure ulcer. SIDERAILS R1 R1's Service Plan dated July 19, 2021, indicated R1 received assistance with dressing, feeding, oral hygiene, hair care and grooming, assistance with toileting, bathing, preparation of a modified diet, medication administration, assistance with two/mechanical lift, eating assistance, laundry, and a three time per day "I'm ok" check. R1's side rail assessment dated September 22, 2021, indicated side rails did "not appear to be indicated at this time." The assessment further indicated "side rails were indicated due to the following medical conditions/symptoms: side rails are not removable from the bed frame. No concerns noted with current plan/services." The assessment indicated the positive and negative aspects of side rails were not discussed with the resident/family and the resident/family were not aware of the risks involved with side rail use. R2 R2's Service Plan dated July 20, 2021, indicated R2 received assistance with dressing, oral hygiene, hair care, grooming, toileting, bathing, medication administration, eating assistance, laundry, housekeeping and linen changes, and three times per day "I'm ok" check. R2's side rail assessment dated October 6, 2021, indicated the resident was not currently using side	02310		

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rails for positioning or support and the resident had not expressed a desire to have side rails in bed. The assessment indicated side rails were "not indicated at this time." The assessment indicated the positive and negative aspects of side rails were not discussed with the resident/family and the resident/family were not aware of the risks involved with side rail use.

On November 3, 2021, at 12:00 p.m. RN-B confirmed side rails were not needed for R1 and R2; however, the beds being utilized by the residents had side rails that could not be removed. RN-B stated the licensee generally goes over the FDA brochure on side rail risks at the time of admission.

The licensee's 6.28 Side rails policy dated August 1, 2021, indicated the licensee would assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of a safe design and utilized consistent with the manufacturer's directions. The policy indicated it would be followed regardless of who owns or is supplying the side rail.

FALLS
R5

R5's Uniform Assessment Tool and individualized abuse prevention plan dated October 27, 2021, and September 15, 2021, respectively, indicated the resident was at risk for falls, lacked safety awareness, and staff should report falls to the nurse and provide frequent reminders to call for help, as well as check resident every two hours.

R5's record included incident reports related to

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falls on September 19, 2021, and October 1, 2021. The incident reports included the following information:
-September 19, 2021, at 3:05 p.m. R5 was found yelling for help in front of her bedroom door facing her bathroom. A skin tear to the right hand was noted, range of motion (ROM) evaluated, vital signs obtained, and staff assisted off the floor. Root cause analysis (RCA) included impaired memory, confused, self-transferring/ambulating with a four wheeled walker, wanderer, lack of safety awareness, recent medication changes. Intervention: does have motion sensor in bedroom, safety checks every two hours, rounding provider to assess medication regimen effectiveness on September 21, 2021.
-October 1, 2021, at 1:03 p.m. R5 was observed to self transfer out of her chair in the dining room. R5 slipped from wheelchair to floor, landing on her right hip. R5's right leg was noted to be rotated outward and R5 complained of pain, was rubbing hip area. Vital signs were noted to be stable, the ambulance was called and R5 was transferred to the emergency room where R5 was later diagnosed with a right hip fracture. RCA noted impaired memory, during self-transfer (sic), lack of safety awareness, wanderer, history of falls, recent changes in medications. Intervention: rounding provider to see on rounding and review medications.

On November 4, 2021, at 10:10 a.m. RN-B confirmed the interventions listed in the September 19, 2021, fall were not new interventions aside from having the provider review medications, and confirmed new interventions were not put in place after the October 1, 2021, fall. R5's room contained a fall mat that was placed by the bed, but it was not listed on the resident's care plan, assessments,

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or service plan. RN-B confirmed the fall mat was not an intervention implemented by nursing and stated, "I don't know why that's there, I think someone has been being too proactive." RN-B confirmed a thorough root cause analysis was not completed with each fall.

On November 4, 2021, at 10:45 a.m. ULP-G wasn't sure if R5 utilized a fall mat or not but knew one was in the resident's room. ULP-G stated she thought the nurses added it as an intervention after her fall on October 1st, but wasn't sure.

On November 4, 2021, at 11:00 a.m. LPN-J confirmed a fall mat was implemented for R5 as soon as her transfer status was downgraded to a hoyer lift. LPN-J stated the fall mat was in the care plan and staff were educated on the fall mat as an intervention. LPN-J stated interventions added after R5's fall included one to one supervision, and a chair alarm.

R15
R15's diagnoses included, but were not limited to, type II diabetes, acute kidney failure, visual loss, depression and antisocial personality disorder.

R15's service plan dated July 19, 2021, indicated R15 required assistance with dressing, hygiene and grooming, toileting, bathing, medication administration, transfer assistance, and "I'm OK" checks, as well as additional housekeeping, laundry and meal services.

R15's Uniform Assessment Tool and individualized abuse prevention plan dated September 28, 2021, and September 29, 2021, respectively, indicated the resident was at risk for

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falling, did not always utilize the call light appropriately, and staff should report falls to the nurse and provide frequent reminders to call for help.

R15's record included incident reports related to falls on September 14, 2021, October 1, 2021, October 5, 2021, and October 11, 2021. The incident reports included the following information:
-September 14, 2021, at 9:30 a.m. R15 was found on the floor between the recliner and wheelchair, was not in any pain, range of motion (ROM) evaluated, vital signs obtained, assist of three and gait belt to assist resident to recliner. Educated on utilizing call light appropriately and allowing time for staff to answer and emphasized importance of locking wheelchair brakes prior to transferring. Root cause analysis (RCA) included history of falls, lack of safety awareness, impaired vision. Intervention: call don't fall signs placed in room and bathroom. Resident verbalized her (sic) can visualize/understand new signs in room.
-October 1, 2021, at 3:52 p.m. R15 was found sitting on floor between the dresser and bed after the call pendant was activated; ROM completed, no pain, vital signs obtained. RCA included weakness, transferring without assistance, resistive to assistance, lack of safety awareness and impaired vision. Intervention: education provided regarding importance of utilizing call pendant for assistance and not self-transferring. Verbalized understanding to utilize call pendant when transferring.
-October 5, 2021, at 4:40 p.m. R15 was found sitting on the bathroom floor after answering R15's call pendant. ROM within normal limits (WNL), obtained vital signs, denied pain, two assist and hoyer to transfer into wheelchair. Small skin tear to right elbow dressed. RCA:

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during self-transfer, lack of safety awareness, impaired vision, weakness, gait imbalance, crowding in bathroom and resistive to cares. Intervention: motion sensor activated in room, education provided utilizing call pendant for assistance with all transfers. Staff to provide frequent reminders on call pendant use.
-October 11, 2021, at 1:45 p.m. R15 as found sitting on the foot in his room after pendant used. R15 stated he was self-transferring from wheelchair to recliner and he didn't activate call pendant until he had fallen. ROM, vital signs WNL. RCA: weakness, lack of safety awareness, resistive to cares, improper footwear, and transferring without assistance. Intervention: education provided regarding importance of call light use. Discussed possible chair alarm, power of attorney contacted regarding approval of adding chair alarm to the service plan.

R15's progress notes from August 1, 2021, thru November 4, 2021, included a note on September 14, 2021, at 1:32 p.m. which summarized the fall and interventions in place. The progress notes lacked documentation on subsequent falls.

On November 3, 2021, at 12:50 p.m. LALD-A and RN-B confirmed new interventions were not always initiated for residents. LALD-A stated falls or trending of falls was not monitored as part of quality management and RN-B stated she did her best to complete an RCA and implement new interventions.

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7) days

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02320 SS=G	144G.91 Subd. 4 Appropriate care and services (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 properly train and to ensure competency in knowing when to notify the registered nurse (RN) of resident related changes in condition for two of two employees (unlicensed personnnel (ULP)-I and licensed practical nurse (LPN)-J). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On November 2, 2021, at approximately 12:15 p.m. licensed assisted living director (LALD)-A confirmed the facility had a registered nurse on call 24 hours a day, seven days a week. R5 was observed on November 3, 2021, at 2:25 p.m. to have unstageable bilateral pressure ulcers to heels. R5's diagnoses included, but were not limited to, Alzheimer's disease, anxiety disorder, and	02320		

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muscle weakness.
R5's service plan dated July 29, 2021, indicated the resident required assistance with dressing, feeding, oral hygiene, hair care, grooming, toileting, weekly laundry and housekeeping, and a three times daily "I'm OK" check.
An incident report from September 19, 2021, indicated R5 obtained a skin tear to the right hand after an unwitnessed fall. The root cause analysis (RCA) included impaired memory, confused, self-transferring/ambulating with a four wheeled walker, wanderer, lack of safety awareness, recent medication changes. Intervention: does have motion sensor in bedroom, safety checks every two hours, rounding provider to assess medication regimen effectiveness on September 21, 2021.
An incident report from October 1, 2021, indicated R5 sustained a right hip fracture after a witnessed fall. No new interventions were implemented after the fall on October 1, 2021.
A Uniform Assessment Tool dated October 5, 2021, indicated R5's transfer status changed to an EZ stand and required an assist of two for ambulation, bed mobility, and transfers. The assessment did not indicate any risk factors or skin issues were present at that time.
Progress notes indicated R5 had a follow up orthopedic appointment on October 21, 2021, where R5 was downgraded to 50% weight bearing on the right hip. Progress notes indicated the resident's walking program was discontinued on October 26, 2021, pending further clarification from orthopedics.
R5's task documentation from October 24, 2021, through October 31, 2021, showed the following documentation for staff monitoring every two hours:
-On October 24, 2021, nine of 12 opportunities for turning/repositioning were missed. There was no

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documentation of repositioning between 5:12 a.m. and 4:13 p.m.
-On October 25, 2021, 10 of 12 opportunities for turning/repositioning were missed. R5 was turned/repositioned at 4:10 a.m. and 12:47 p.m., no further documentation was entered that day.
-On October 26, 2021, 11 of 12 opportunities for turning/repositioning were missed. R5 was turned at 4:40 p.m., no further documentation for turning/repositioning was entered that day.
-On October 27, 2021, 11 of 12 opportunities for turning/repositioning were missed. R5 was turned at 4:14 p.m., no further documentation for turning/repositioning was entered that day.
-On October 28, 2021, 12 of 12 opportunities for turning/repositioning were missed. R5 did not have documentation for turning/repositioning entered that day.
-On October 29, 2021, eight of 12 opportunities for turning/repositioning were missed. R5 went nine hours between turning from 2:01 p.m. to 9:28 p.m.
-On October 30, 2021, eight of 12 opportunities for turning/repositioning were missed. R5's last documented turning and repositioning for the day was at 1:00 p.m.
-On October 31, 2021, 11 of 12 opportunities for turning/repositioning were missed. R5 was turned at 1:13 a.m., no further documentation for turning/repositioning was entered that day.
A progress note completed by LPN-B dated October 27, 2021, indicated R5 had stage one pressure ulcers to both heels. No further notes were entered after this date and measurements were not obtained. The note indicated home health wound care was to evaluate and treat.
A clinical communication tool dated October 28, 2021, indicated the resident was to be turned and repositioned every 1.5 to 2 hours.
On November 3, 2021, at approximately 12:00

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	30718	A. BUILDING: _____ B. WING _____	11/04/2021

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

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02320	Continued From page 90 p.m. RN-B stated R5 had unstageable, intact pressure ulcers to both heels and a contracted home health agency was managing wound care for R5. RN-B confirmed no measurements had been taken and no documentation was done after October 27, 2021, because the licensee did not manage wound care and they had made a referral to a home care provider to manage the wounds. On November 3, 2021, at 12:30 p.m. RN-B stated she was told "we try to stay away from nursing care" by licensed practical nurse (LPN)-C "so we try not to do nursing stuff and have home care do it instead." RN-B stated since she was only onsite two days a week, she had not had a chance to assess the wound this week, was not aware the right heel had opened up and was not sure if the home care agency had been able to assess the pressure ulcers. On November 3, 2021, at approximately 12:40 p.m. RN-B stated she would expect staff to be turning and repositioning R5 at least every two hours due to noted skin breakdown and decrease in mobility. RN-B was unsure how often R5 had been turned and repositioned in the days leading up to the resident developing pressure ulcers to both heels. RN-B confirmed the documentation entered for the resident's tasks were not completed in a timely manner and did not reflect the actual times services were performed. On November 3, 2021, at 2:25 p.m. RN-B assessed R5's heels. RN-B stated, "This is bigger than when I saw it last week. It's way worse than I thought it was." RN-B stated she would have assumed orders were obtained for R5's pressure ulcers and felt that the open wound should have a dressing on it. RN-B measured R5's wounds and noted R5 was exhibiting facial grimacing while taking measurements. R5's left heel pressure ulcer measured 2.3 centimeters	02320		

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02320	Continued From page 91	02320		

(cm) x 2.9 cm. R5's right heel pressure ulcer measured 4.5 cm x 5.3 cm, with the open area of the pressure ulcer measuring 2.7 cm x 2.3 cm. RN-B confirmed staff had not been dressing the open wound and had not initiated any kind of dressing or wound care while waiting for home care to begin.
The home care agency assessed the resident on November 3, 2021, and wound care was initiated November 4, 2021.
On November 4, 2021, at approximately 10:30 a.m. LPN-C stated that RN-B was not aware of the worsening pressure ulcers until Tuesday afternoon (November 2, 2021) as it was their procedure to notify the RN within 24 hours if the issue was not emergent; however, in an earlier interview with RN-B on November 3, 2021, RN-B indicated she had not been notified of the worsening pressure ulcer and was not aware of the change of condition until updated by the surveyor.
On November 4, 2021, at approximately 10:45 a.m. unlicensed personnel (ULP)-I stated she noticed R5's pressure ulcer opened late Saturday night (October 30, 2021) into early Sunday morning (October 31, 2021). ULP-I stated she believed the RN was notified, but was not sure. ULP-I stated she notified the LPN on Monday (November 1, 2021) about the worsening pressure ulcer. ULP-I wasn't sure if that was something the RN should be immediately notified of. If they had to report an urgent issue, they would usually call the on call number; otherwise, they would talk to the nurse when they came in. ULP-I was not sure if the on call nurse was a RN.
On November 4, 2021, at approximately 10:55 a.m. LPN-J stated staff notified her of the worsening pressure ulcer on Monday (November 1, 2021) morning, approximately 24 hours after the pressure ulcer opened. LPN-J confirmed she

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02320	Continued From page 92 did not immediately notify the RN since the issue was not emergent. The resident's chart lacked evidence the provider and home care was notified of the worsening pressure ulcer. The nursing schedule dated September 27, 2021, thru November 13, 2021, indicated the scheduled on-call nurse for each day was a licensed practical nurse, not a registered nurse. On November 3, 2021, at approximately 12:35 p.m. LALD-D stated if the LPN was called, they would be the one who called the RN, if warranted. The licensee's 6.12 Availability of an RN for Staff policy dated August 1, 2021, indicated a registered nurse must be available for consultation by staff performing delegated nursing tasks, must be readily available either in person, by telephone, or by other means to the staff at all times when the staff are providing services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to	03000		

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03000	Continued From page 93 believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center	03000		

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(MAARC) suspected maltreatment and complete a thorough investigation for two of two residents (R5 and R19) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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:

The licensee failed to immediately report to MAARC pressure ulcer development for R5 and elopement for R19.

R5
R5 was observed on November 3, 2021, at 2:25 p.m. to have unstageable bilateral pressure ulcers to heels.

R5's diagnoses included, but were not limited to, Alzheimer's disease, anxiety disorder, and muscle weakness.

R5's Service Plan dated July 29, 2021, indicated the resident required assistance with dressing, feeding, oral hygiene, hair care, grooming, toileting, weekly laundry and housekeeping, and a three times daily "I'm OK" check.

An incident report from September 19, 2021, indicated R5 obtained a skin tear to the right hand after an unwitnessed fall. The root cause analysis (RCA) included impaired memory, confused, self-transferring/ambulating with a four wheeled walker, wanderer, lack of safety

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awareness, recent medication changes. Intervention: does have motion sensor in bedroom, safety checks every two hours, rounding provider to assess medication regimen effectiveness on September 21, 2021.

An incident report from October 1, 2021, indicated R5 sustained a right hip fracture after a witnessed fall. No new interventions were implemented after the fall on October 1, 2021.

A Uniform Assessment Tool dated October 5, 2021, indicated R5's transfer status changed to an EZ stand and required an assist of two for ambulation, bed mobility, and transfers. The assessment did not indicate any risk factors or skin issues were present at that time.

Progress notes indicated R5 had a follow up orthopedic appointment on October 21, 2021, where R5 was downgraded to 50% weight bearing on the right hip. Progress notes indicated the resident's walking program was discontinued on October 26, 2021, pending further clarification from orthopedics.

R5's task documentation from October 24, 2021, through October 31, 2021, showed the following documentation for staff monitoring every two hours:
-On October 24, 2021, nine of 12 opportunities for turning/repositioning were missed. There was no documentation of repositioning between 5:12 a.m. and 4:13 p.m.
-On October 25, 2021, 10 of 12 opportunities for turning/repositioning were missed. R5 was turned/repositioned at 4:10 a.m. and 12:47 p.m., no further documentation was entered that day.
-On October 26, 2021, 11 of 12 opportunities for turning/repositioning were missed. R5 was turned

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at 4:40 p.m., no further documentation for turning/repositioning was entered that day.
-On October 27, 2021, 11 of 12 opportunities for turning/repositioning were missed. R5 was turned at 4:14 p.m., no further documentation for turning/repositioning was entered that day.
-On October 28, 2021, 12 of 12 opportunities for turning/repositioning were missed. R5 did not have documentation for turning/repositioning entered that day.
-On October 29, 2021, eight of 12 opportunities for turning/repositioning were missed. R5 went nine hours between turning from 2:01 p.m. to 9:28 p.m.
-On October 30, 2021, eight of 12 opportunities for turning/repositioning were missed. R5's last documented turning and repositioning for the day was at 1:00 p.m.
-On October 31, 2021, 11 of 12 opportunities for turning/repositioning were missed. R5 was turned at 1:13 a.m., no further documentation for turning/repositioning was entered that day.

A progress note completed by LPN-B dated October 27, 2021, indicated R5 had stage one pressure ulcers to both heels. No further notes were entered after this date and measurements were not obtained. The note indicated home health wound care was to evaluate and treat.

A clinical communication tool dated October 28, 2021, indicated the resident was to be turned and repositioned every 1.5 to 2 hours.

On November 3, 2021, at approximately 12:00 p.m. registered nurse (RN)-B stated R5 had unstageable, intact pressure ulcers to both heels and a contracted home health agency was managing wound care for R5. RN-B confirmed no measurements had been taken and no

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documentation was done after October 27, 2021, because the licensee did not manage wound care, and a referral had been made to a home care provider for wound care.

On November 3, 2021, at 12:30 p.m. RN-B stated she was told "we try to stay away from nursing care" by LPN-C "so we try not to do nursing stuff and have home care do it instead." RN-B stated since she was only onsite two days a week, she had not had a chance to assess the wound this week. RN-B was not aware the right heel wound had opened, and was not sure if the home care agency had been able to assess the pressure ulcers.

On November 3, 2021, at approximately 12:40 p.m. RN-B stated she would expect staff to be turning and repositioning R5 at least every two hours due to noted skin breakdown and decrease in mobility. RN-B was unsure how often R5 had been turned and repositioned in the days leading up to the resident developing pressure ulcers to both heels. RN-B confirmed the documentation entered for the resident's tasks were not completed in a timely manner and did not reflect the actual times services were performed.

On November 3, 2021, at 2:25 p.m. RN-B assessed R5's heels. RN-B stated, "This is bigger than when I saw it last week. It's way worse than I thought it was." RN-B stated she would have assumed orders were obtained for R5's pressure ulcers and felt that the open wound should have a dressing on it right now. RN-B measured R5's wounds and noted R5 was exhibiting facial grimacing while taking measurements. R5's left heel pressure ulcer measured 2.3 centimeters (cm) x 2.9 cm. R5's right heel pressure ulcer measured 4.5 cm x 5.3

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cm, with the open area of the pressure ulcer measuring 2.7 cm x 2.3 cm. RN-B confirmed staff had not been dressing the open wound and had not initiated any kind of dressing or wound care while waiting for home care to assess.

The home care agency assessed the resident on November 3, 2021, and wound care was initiated November 4, 2021.

On November 4, 2021, at approximately 10:30 a.m. LPN-C stated that RN-B was not aware of the worsening pressure ulcers until "Tuesday" (November 2, 2021) afternoon as it was their procedure to notify the RN within 24 hours if the issue was not emergent; however, in an earlier interview with RN-B on November 3, 2021, RN-B indicated she had not been notified of the worsening pressure ulcer and was not aware of the change of condition until updated by the surveyor.

On November 4, 2021, at approximately 10:45 a.m. unlicensed personnel (ULP)-I stated she noticed R5's pressure ulcer opened "late Saturday night" (October 30, 2021) "into early Sunday morning" (October 31, 2021). ULP-I stated she believed the RN was notified, but was not sure. ULP-I stated she notified the LPN on "Monday" (November 1, 2021) about the worsening pressure ulcer. ULP-I wasn't sure if that was something the RN should be immediately notified of. If they had to report an urgent issue, they would usually call the on call number; otherwise, they would talk to the nurse when they came in. ULP-I was not sure if the on call nurse was a RN.

On November 4, 2021, at approximately 10:45 a.m. LPN-J stated she, LPN-C and LALD-A

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discussed the worsening pressure ulcers, but felt since the care plan was being followed and the family was aware of the pressure ulcers, they did not feel it was reportable. LPN-J confirmed RN-B was not involved in this decision making process or that it was determined to be not reportable. LPN-J confirmed RN-B was not updated on the worsening pressure ulcers until the afternoon of Tuesday, November 2, 2021; however, in a subsequent interview with RN-B on November 3, 2021, RN-B indicated she had not been notified of the worsening pressure ulcer and was not aware of the change of condition until updated by the surveyor. The resident's chart lacked evidence the provider and home care was notified of the worsening pressure ulcer.

R19
R19's diagnoses included, but were not limited to, dementia, muscle weakness, depression, and restless leg syndrome.

R19's service plan dated July 20, 2021, indicated the resident required assistance with dressing, oral hygiene, hair care, grooming, toileting, bathing, medication administration, weekly laundry and housekeeping and three times daily "I'm OK" checks.

R19's record included an incident report for elopement on August 9, 2021, at 10:00 a.m. The incident report indicated R19 was confused, forgetful and anxious. The report indicated R19 had a wanderguard on at the time of the elopement, during which R19 was found in a car in the west parking lot. At the time of the incident, R19 was not residing in the memory care unit. The incident report noted LALD-A had checked R19's wanderguard on August 7, 2021, and it was

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03000	Continued From page 100 functional at that time. R19's individual abuse prevention plan, undated, noted R19 had a diagnosis of dementia and required staff to monitor for safety; was unable to summons for assistance due lack of understanding of call light and had safety checks every two hours and a motion sensor alarm in her apartment; and was at risk for elopement with multiple elopement attempts which resulted in memory care placement. R19's record lacked documentation of the incident. R19's record included a uniform assessment tool dated September 1, 2021, which indicated R19 was at a high risk for elopement. On November 4, 2021, at 10:50 a.m. RN-B stated R19 was not residing in the locked unit at the time of the elopement, and had a wanderguard on at the time; however, the wanderguard had failed. RN-B stated "it was a bad scenario" and R19 was moved to the locked memory care unit on September 1, 2021. RN-B confirmed a MAARC report was not made, and stated she did not feel a report was necessary since R19 had not been injured, and interventions such as the wanderguard, were in place. On November 4, 2021, at 10:55 a.m. LALD-A confirmed she had been made aware of the incident and a MAARC report had not been filed. LALD-A stated the decision to report or not report was made by using the Care Provider's diagram for vulnerable adult reporting. LALD-A stated "I suppose thinking about it now, it should have been reported."	03000		

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03000	Continued From page 101 The licensee's 2.44 Vulnerable Adult Maltreatment - Prevention & Reporting policy dated August 1, 2021, noted staff who suspect maltreatment of a resident (abuse, financial exploitation, or neglect) or who has knowledge that a resident has sustained a physical injury which is not reasonably explained will: a. Take immediate action to protect, or keep safe, the resident affected; b. Call 911 if emergency assistance is needed; c. Contact the Clinical Nurse Supervisor if medical attention is needed; d. Contact the Assisted Living Director; e. The Assisted Living Director or Clinical Nurse Supervisor will determine how to best protect other residents from similar maltreatment in the immediate future; f. If the Assisted Living Director or Clinical Nurse Supervisor confirms the suspicion of maltreatment, they will contact MAARC. Such report must be made no later than 24 hours after the maltreatment was first suspected. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03000		

Minnesota Department of Health

PO Box 64495
St Paul, Minnesota
651-201-4500

Type: Full
Date: *11/02/21*
Time: 12:15:59
Report: 1008211049

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.

The following orders were issued during this inspection.

5-200B Plumbing: cross connections

5-203.14 ** Priority 1 **

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

THERE IS A Y CONNECTOR ON THE FAUCET ON THE THREE COMPARTMENT SINK. A BLACK HOSE IS CONNECTED TO BOTH SIDES OF THE Y. AT THE END OF ONE OF THE HOSES IS A BACKFLOW PREVENTER WHERE IT CONNECTS TO A CHEMICAL DISPENSER. CONTINUED IN GENERAL COMMENTS.

Comply By: 11/03/21

5-200C Plumbing: Maintenance, fixture location

5-205.11AB ** Priority 2 **

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

HANDWASHING SINKS SHALL BE USED ONLY FOR HANDWASHING AND SHALL BE ACCESSIBLE AT ALL TIMES. DURING INSPECTION HANDWASHING SINK IN COOKING AREA WAS BLOCKED BY PANS.

Comply By: 11/02/21

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

I WAS TOLD THERE WAS A CHANGE IN KITCHEN MANAGER LAST WEEK. ENSURE A NEW CFPM IS EMPLOYEED.
E. A FOOD EXTABLISHMENT THAT CEASES TO EMPLOY A CFPM SHALL EMPLOY A NEW CFPM WITHIN 60 DAYS.

Comply By: 12/30/21

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

REMOVE DOMESTIC EQUIPMENT WITHIN THE KITCHEN THAT IS REQUIRED TO BE ANSI CERTIFIED: COUNTERTOP FOOD PROCESSOR AND GRIDDLE STORED ON TOP OF THE COOLER.

Comply By: 11/04/21

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

THE SERVICE KITCHEN THAT HAS DOMESTIC EQUIPMENT AND CABINETRY SHALL DISCONTINUE SERVING TCS (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) FOODS THAT ARE HELD FOR MORE THAN SAME-DAY SERVICE. CONTINUED IN GENERAL COMMENT.

Comply By: 11/02/21

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

RELOCATE THE THERMOMETER WITHIN THE WALK-IN COOLER SO THAT IT IS EASILY READ. CURRENTLY THE THERMOMETER IS BEHIND SHELVING AND PART OF THE THERMOMETER CAN NOT BE READ.

Comply By: 11/03/21

Surface and Equipment Sanitizers

Hot Water: = at 184 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Walk-In Cooler
Temperature: 40 Degrees Fahrenheit - Location: LUNCH MEAT
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Cooking
Temperature: 184 Degrees Fahrenheit - Location: CHICKEN
Violation Issued: No

Process/Item: Hot Holding
Temperature: 170 Degrees Fahrenheit - Location: GRAVY
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: HOT DISH
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	1	4

CONTINUED FROM 4-201.11GMN: FOOD THAT IS TCS SHALL BE PREPARED AND TRANSPORTED TO THE SERVICE KITCHEN FOR SERVICE ONLY. NO TCS FOOD SHALL BE STORED IN THE REFRIGERATOR IN THE SERVICE KITCHEN. REMOVE/DISCARD FROM THE ESTABLISHMENT ALL TCS FOOD WITHIN THE REFRIGERATOR IN THE SERVICE KITCHEN.

CONTINUED FROM 5-203.14: THE OTHER SIDE OF THE Y IS AN OPEN ENDED HOSE THAT SITS IN THE BOTTOM OF THE SINK. RELOCATE THE BACKFLOW PREVENTER SO THAT IT IS ABOVE THE Y CONNECTOR SO THAT IT PROTECTS BOTH SIDES OF THE Y.

THINGS TO REMEMBER:

1 THE CERTIFIED FOOD PROTECTION MANAGER SHOULD BE ROUTINELY CONDUCTING SELF INSPECTIONS TO ENSURE THAT EMPLOYEES ARE FOLLOWING PROPER FOOD HANDLING PRACTICE.

2 EDUCATE EMPLOYEES ON THE IMPORTANCE OF REPORTING TO MANAGEMENT ANY ILLNESS THEY HAVE OR HAVE HAD RECENTLY. MANAGEMENT SHOULD EXCLUDE ANY WORKERS ILL WITH VOMITING OR DIARRHEA FROM HANDLING FOOD, AND THEY SHOULD KEEP AN UP TO DATE EMPLOYEE ILLNESS LOG.

3 THERE SHOULD BE A PERSON IN CHARGE A THE ESTABLISHMENT DURING ALL HOURS OF OPERATION. THIS PERSON SHOULD ENSURE THAT EMPLOYEES ARE PRACTICING GOOD HAND WASHING PROCEDURES, INCLUDING BEING KNOWLEDGEABLE ABOUT WHEN HAND WASHING SHOULD BE DONE AND HOW TO PROPERLY WASH HANDS.

4. EMPLOYEES SHOULD USE SPATULA, TONGS, DELI TISSUE, GLOVES OR SOME OTHER APPROVED MEANS TO PREVENT ANY DIRECT BARE HAND CONTACT WITH READY TO EAT FOODS.

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 1008211049 of 11/02/21.

Certified Food Protection Manager: PENDING

Certification Number: _____ Expires: / /

Signed: emailed to HRD
Establishment Representative

Signed: Inspector ID# 1088

Public Health Sanitarian 3
Fergus Falls District Office
651-201-4500
health.foodlodging@state.mn.us

Report #: 1008211049

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
PO Box 64495
St Paul, Minnesota

No. of RF/PHI Categories Out	2	**Date**	11/02/21
No. of Repeat RF/PHI Categories Out	0	**Time In**	12:15:59
Legal Authority MN Rules Chapter 4626		**Time Out**	

Alex Assisted Living Llc	**Address** 90 East Lake Cowdry Road Nw	**City/State** Alexandria, MN	**Zip Code** 56308	**Telephone** 3207628345
License/Permit # 0038026	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

	Compliance Status		COS	R
	Supervision			
1	(IN) OUT	PIC knowledgeable; duties & oversight		
2	IN (OUT) N/A	Certified food protection manager, duties		
	Employee Health			
3	(IN) OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN) OUT	Proper use of reporting, restriction & exclusion		
5	(IN) OUT	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices			
6	(IN) OUT N/O	Proper eating, tasting, drinking, or tobacco use		
7	(IN) OUT N/O	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands			
8	(IN) OUT N/O	Hands clean & properly washed		
9	(IN) OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN (OUT)	Adequate handwashing sinks supplied/accessible		
	Approved Source			
11	(IN) OUT	Food obtained from approved source		
12	IN OUT N/A (N/O)	Food received at proper temperature		
13	(IN) OUT	Food in good condition, safe, & unadulterated		
14	IN OUT (N/A) N/O	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
15	(IN) OUT N/A N/O	Food separated and protected		
16	(IN) OUT N/A	Food contact surfaces: cleaned & sanitized		
17	(IN) OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	(IN) OUT N/A N/O	Proper cooking time & temperature		
19	IN OUT N/A (N/O)	Proper reheating procedures for hot holding		
20	IN OUT N/A (N/O)	Proper cooling time & temperature		
21	(IN) OUT N/A N/O	Proper hot holding temperatures		
22	(IN) OUT N/A	Proper cold holding temperatures		
23	(IN) OUT N/A N/O	Proper date marking & disposition		
24	IN OUT (N/A) N/O	Time as a public health control: procedures & records		
	Consumer Advisory			
25	IN OUT (N/A)	Consumer advisory provided for raw/undercooked food		
	Highly Susceptible Populations			
26	(IN) OUT N/A	Pasteurized foods used; prohibited foods not offered		
	Food and Color Additives and Toxic Substances			
27	(IN) OUT N/A	Food additives: approved & properly used		
28	(IN) OUT	Toxic substances properly identified, stored, & used		
	Conformance with Approved Procedures			
29	IN OUT (N/A)	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
		Safe Food and Water		
30	(IN) OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	(IN) OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A (N/O)	Approved thawing methods used		
36	X	Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51	X	Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) emailed to HRD **Date:** 11/03/21

Inspector (Signature) Inspector ID# 1008