Electronically Delivered

June 29, 2026

Licensee
Alabama Residency
14438 Alabama Avenue South
Savage, MN 55378

RE: Project Number(s) SL39541016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 20, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

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 may be 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;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

pursuant to this survey:

St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00
St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $500.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $2,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers.

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

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39541	A. BUILDING: _____ B. WING _____	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALABAMA RESIDENCY	14438 ALABAMA AVENUE SOUTH SAVAGE, MN 55378

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(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: SL39541016-0 On May 18, 2026, through May 20, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were five resident(s); five receiving services under the Assisted Living Facility license. 2310: An immediate order was identified on May 19, 2026, at a level 3/Widespread (I). The licensee took immediate action; howerver, the scope and level remain at I.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	0 780		

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

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0 780	Continued From page 2 resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May 20, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) days.	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.	0 800		

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0 800	Continued From page 3 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May 20, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.	0 810		

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0 810	Continued From page 4 (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 810		

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0 810	Continued From page 5 Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May 20, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	0 810		
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking for one of one resident (R2). This had the potential to affect all staff, residents, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	0 830		

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0 830	Continued From page 6 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 May 19, 2026, at 9:37 a.m., unlicensed personnel (ULP)-D removed a cigarette from R2's pack and handed it to her. R2 went with ULP-D into the garage, leaving the door from the house into the garage open. The garage had a ramp from the door of the house into the garage, a table with a couple chairs and a commercial ashtray next to the table. The garage door was open to the outside. R2 asked staff to close the garage door because it was cold. ULP-D lit the cigarette for R2, and R2 began smoking near the bottom of the ramp in the garage. ULP-D stated R2 smokes in the garage and the garage door to the outside had to remain open while residents were smoking; it has always been that way. The surveyor re-entered the home and could smell cigarette smoke in the kitchen and living room area. At 9:50 a.m., R2 finished her cigarette and returned from the garage into the home. On May 19, 2026, at 12:36 p.m., licensed assisted living director (LALD)-B stated staff are required to be within site of R2, but do not have to be right beside her when she smokes. LALD-B stated R2 has the right to smoke in the garage, and R2 refuses to go outside. On May 20, 2026, at 6:28 a.m., R2 requested to smoke. R2 began arguing with the unlicensed staff and licensed assisted living director/registered nurse (LALD/RN)-A, stating she doesn't have to sit outside to smoke, and she always smokes in the garage; just because the state is at the facility, they now make her sit	0 830		

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0 830	Continued From page 7 outside. R2 was sitting just outside the garage door with the garage door open and the door to the home ajar. R2 returned into the garage with her lit cigarette stating "I can be inside, I am always inside. It is not a law, so stop saying it is." ULP-D moved the ashtray back into the garage next to R2, who finished her cigarette in the garage. The licensee's Smoking Policy dated January 1, 2023, included: To provide a safe, healthy, and smoke-free environment for residents, staff, and visitors while complying with: - The Minnesota Clean Indoor Air Act (MCIAA) - Minnesota assisted living regulations - Federal fire and safety standards - OSHA workplace safety expectations Policy Statement The facility prohibits smoking, vaping, and the use of electronic smoking devices in all indoor areas of the assisted living facility except in a designated enclosed smoking room that complies with Minnesota law and facility policy. This policy applies to: - Residents - Staff - Visitors - Volunteers - Contractors The facility recognizes resident rights while maintaining safety, infection control, fire prevention, and protection from secondhand smoke exposure. Under the Minnesota Clean Indoor Air Act, smoking and vaping are prohibited in most indoor public places and workplaces, including healthcare facilities. Assisted living facilities may only permit indoor smoking in a designated	0 830		

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0 830	Continued From page 8 separate enclosed room maintained according to state and federal requirements. Indoor Smoking Restrictions Smoking and vaping are prohibited in: - Resident rooms (unless specifically approved under designated smoking-room requirements) - Hallways - Dining areas - Medication rooms - Bathrooms - Offices - Common areas - Activity rooms - Vehicles used for resident transportation - Any indoor workspace used by employees The Minnesota Clean Indoor Air Act prohibits smoking in indoor public places and places of employment. Designated Smoking Area If the facility permits smoking: - Smoking shall occur only in a designated separate enclosed room or approved outdoor smoking area. - The designated smoking room must comply with state and federal ventilation and safety requirements. - Appropriate signage must be posted stating: o "Smoking Prohibited Except in Designated Areas" o "Smoking Permitted" at approved smoking rooms. Minnesota law specifically requires smoking in assisted living facilities to be limited to a designated separate enclosed room. Staff, visitors, and volunteers may not smoke indoors in the facility. Outdoor Smoking Outdoor smoking may be permitted in designated	0 830		

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0 830	Continued From page 9 areas approved by the facility. Residents and visitors must: - Stay away from oxygen equipment - Properly dispose of smoking materials - Follow facility supervision requirements The MCIAA does not prohibit outdoor smoking statewide, although local ordinances may impose additional restrictions near entrances and windows. Resident Safety Residents who smoke may require: - Smoking assessments - Supervision during smoking - Safe storage of smoking materials - Care plan interventions Smoking is prohibited: - While oxygen is in use - Near oxygen tanks or concentrators - Near combustible materials The Minnesota Clean Indoor Air Act (MCIAA) amendment effective on August 1, 2019, noted smoking was prohibited in health care facilities and clinics. In addition, an indoor area meant a space between a floor and a ceiling that is at least half enclosed by walls, doorways, or windows (opened or closed) around the perimeter. A wall included retractable dividers, garage doors, plastic sheeting or any other temporary or permanent physical barrier. Minnesota State Statute 144.414 Prohibitions; Subdivision 3 dated 2022, indicated under a section titled Health care facilities and clinics: (a) Smoking was prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility,	0 830		

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0 830	Continued From page 10 or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws. No further information was provided. TIME TIME PERIOD FOR CORRECTION: Seven (7) days	0 830		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring	01620		

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01620	Continued From page 11 in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) 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. (f) 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 accurately assess and implement interventions related to smoking for the licensee's one resident (R2) who smoked, and the licensee failed to complete a comprehensive assessment at least every 90 days as required for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39541	A. BUILDING: _____ B. WING _____	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALABAMA RESIDENCY	14438 ALABAMA AVENUE SOUTH SAVAGE, MN 55378

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01620	Continued From page 12 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted August 31, 2023, with diagnoses including bipolar disorder, history of cerebrovascular accident (stroke), and nicotine dependence disorder. On May 19, 2026, at 8:07 a.m., the surveyor observed R2 sitting in an electric wheelchair with a blanket covering her. The blanket had many small circular black marks and holes all the way through to a white inner layer with black surrounding the holes. On May 19, 2026, at 9:37 a.m., the surveyor observed unlicensed personnel (ULP)-D provide feeding assistance to R2. R2 then requested to smoke a cigarette. ULP-D removed a cigarette from R2's pack and handed it to her. R2 went with ULP-D into the garage, leaving the door from the house into the garage open. The garage had a ramp from the door of the house into the garage, a table with a couple chairs, a commercial ashtray next to the table, and a smoking apron hanging next to the table. The garage door was open to the outside. R2 asked staff to close the garage door because it was cold. ULP-D used a lighter hanging around R2's neck to light the cigarette for R2 and R2 began smoking. ULP-D stated R2 smokes in the garage and the garage door to the outside had to remain open while residents were smoking. At 9:50 a.m., R2 finished her cigarette and returned from the garage into the home. On May 19, 2026, at 12:36 p.m., licensed	01620		

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01620	Continued From page 13 assisted living director (LALD)-B stated R2 doesn't like the smoking apron. If staff are leaving R2 unattended, then staff should lay the smoking apron on R2's lap because R2 might drop the lit cigarette into her lap. LALD-B stated R2 used to be on oxygen and smoked with her oxygen on; however, the oxygen had been discontinued. LALD-B further stated staff are required to be within site of R2, but do not have to be right beside her when she smokes. On May 20, 2026, at 6:28 a.m., R2 requested to smoke. ULP-D went out to the garage with R2 and brought the smoking apron to R2. R2 refused to wear the apron stating, "I have never used that before." Licensed assisted living director/registered nurse (LALD/RN)-A approached R2 and stated she can refuse it if she wanted to. ULP-D lit the cigarette using a lighter hanging around R2's neck R2 was stating she doesn't have to sit outside to smoke. She always smokes in the garage; just because the state is at the facility, they now make her sit outside. R2 sat just outside the garage door with the garage door open and the door to the home ajar. R2 returned into the garage with her lit cigarette stating, "I can be inside, I am always inside. It is not a law, so stop saying it is." ULP-D moved the ashtray back into the garage next to R2, who finished her cigarette in the garage. R2's comprehensive assessment dated February 4, 2026, included the following: - "Resident smokes more than 20 cigarettes a day she smokes outside the house. Staff to remain with resident when smoking." - "Resident tries to light lighter while using oxygen. Staff to store lighter in medication cabinet and give the lighter to the resident when she goes to smoke and take it back when she is	01620		

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01620	Continued From page 14 done for safety measures." - The assessment further indicated there are no signs in the apartment of mishandled cigarettes such as burns in carpet or furniture R2's record lacked documentation of smoking supervision or attempted use of a smoking apron for R2. R2's record included the following assessments for R2: - November 5, 2025, Clinical Update Assessment; - February 4, 2026, Clinical Update Assessment; this was 91 days between assessments; and - at the time of survey May 20, 2026, no further assessment had been completed and it had been 105 days since the last assessment. On May 19, 2026, at 12:30 p.m., clinical nurse supervisor (CNS)-C stated assessments were to be completed every 90 days. The licensee's Nursing Assessment policy dated Jan 1, 2023, included: - The Registered Nurse (RN) will conduct a comprehensive assessment for all residents admitted to [licensee] to determine the services required and to develop an individualized care plan for staff to implement. The assessment addresses the resident's physical, mental and cognitive needs. - Based on the assessment, the RN will work with the resident/responsible party to prepare an individualized home health aide care plan addressing the home care services needed. - Ongoing resident reassessments must be conducted by an RN and cannot exceed 90 days from the last date of assessment.	01620		

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01620	Continued From page 15 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as prescribed for four of four residents (R2, R3, R5, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	01760		

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01760	Continued From page 16 The findings include: R2 On May 20, 2026, at 7:16 a.m., the surveyor observed unlicensed personnel (ULP)-D administering medications to R2. The medications included an albuterol inhaler 2 puffs administered by ULP-D. R2's medication administration record (MAR) dated May 2026, included Albuterol HFA inhale 1-2 puffs by mouth every 4 hours while awake which was being administered and signed off by staff in the a.m., mid-day, and p.m. The documentation did not indicate if one or two puffs were administered and based on the medication administration times indicated, the medication would not be administered every four hours while awake. R2's physician orders dated February 5, 2026, included albuterol inhaler, inhale 2 puffs every 6 hours as needed for shortness of breath. The orders did not include a scheduled dose of albuterol. On May 20, 2026, at 9:24 a.m., clinical nurse supervisor (CNS)-C stated she did not have an order for R2's scheduled albuterol inhaler and would have to obtain it from the pharmacy. The medication times for the albuterol was how the pharmacy had entered them into the MAR. R3 On May 20, 2026, at 7:07 a.m., the surveyor observed ULP-D administering medications to R3.	01760		

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01760	Continued From page 17 R3's MAR dated May 2026, included Senna Concentrate/Docusate Sodium take one tablet by mouth daily for constipation and was signed off daily in the evening. On May 20, 2026, at 10:20 a.m., the surveyor observed licensed assisted living director/registered nurse (LALD/RN)-A tearing off the signature page from physicians orders, removing a printed med list from the printer and stapled the signature page to the printed med list. The surveyor requested the signature page be attached to the original document. LALD/RN-A stated he thought I wanted a current list and reattached the signature page to the original document. R3's physician orders dated February 13, 2026, included docusate sodium/sennosides 1 tablet by mouth twice daily as needed. The orders did not include a scheduled dose. On May 20, 2026, at 10:40 a.m., the surveyor requested a copy of the order for Senna/ docusate sodium and CNS-C stated she would contact the pharmacy and request it. R5 On May 20, 2026, at 1:20 p.m., the surveyor observed licensed assisted living director (LALD)-B administering medications to R5. R5's MAR dated May 2026, included the following: - levothyroxine 112 micrograms (mcg) give one tab by mouth every morning on an empty stomach, and was signed off daily at 8:00 a.m. by staff; - olapatadine eye drops one drop in both eyes daily by self-administration;	01760		

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01760	Continued From page 18 - fexofenadine 180 milligrams (mg) take one tablet by mouth daily was scheduled at 8:00 p.m. and was signed daily by staff - cetirizine 10 mg take one tablet every day scheduled at 8:00 a.m. and was signed off daily by staff; R5's physician orders included: - December 18, 2026 - - cetirizine 10 mg take one tablet every day - sucralfate 1 gram before meals and at bedtime - May 15, 2026 - quetiapine 200 mg take one tab by mouth every night R5's record review by the surveyor identified the following discrepancies: - no order for levothyroxine - no order for olapatadine - no order for fexofenadine - duplicate therapy of fexofenadine and cetirizine was being signed off as administered - quetiapine was not on the medication administration record and therefore was not being documented as administered by the staff. On May 20, 2026, at 12:05 p.m., CNS-C stated the quetiapine should have been on the MAR and according to the pharmacy, the sucralfate was discontinued in February. CNS-C did not have an order to discontinue, as she used the pharmacy. R6 On May 18, 2026, at 1:20 p.m., the surveyor observed ULP-D administering medications to R6. On May 20, 2026, at approximately 12:30 p.m., the licensee provided signed physician orders with a signature page that indicated "see AVS	01760		

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01760	Continued From page 19 after visit summary," dated April 24, 2026, which included medication order changes after April 24, 2026. This included Coreg 25 mg, effective date of May 4, 2026. On May 20, 2026, at 12:48 a.m., the surveyor showed CNS-C that the orders were changed after the signature page was signed, CNS-C provided the AVS that the signature page had been attached to. R6's MAR dated May 2026, included: - Coreg 12.5 mg daily was increased on the MAR on May 18, 2026, to 25 mg. - Folic acid 1 mg tab started on May 18, 2026. In addition, the following was not signed off as administered or held on the MAR on one or more of the following dates: May 2, 3, 4, and 6, 2026: - Valsartan 160 mg by mouth daily - acetaminophen 1000 mg twice a day 8:00 a.m. - Arnuity inhaler 1 puff daily - aspirin 81 mg by mouth daily - atorvastatin 40 mg by mouth every day - hydrochlorothiazide 125 mg by mouth daily - levothyroxine 75 mcg by mouth daily - multivitamin 1 tab by mouth daily - naltrexone 50 mg by mouth daily - pantoprazole 40 mg by mouth daily - Coreg 12.5 mg by mouth twice a day at bedtime - trazadone 50 mg by mouth at bedtime R6's AVS dated April 24, 2026, included: - Coreg increased from 12.5 mg to 25 mg daily - folic acid 1 mg by mouth daily R5's pharmacy order dated May 4, 2026, included Coreg 25 mg one tablet by mouth every day. On May 20, 2026, at 1:23 p.m., CNS-C stated she is unsure if the correct dose of Coreg had	01760		

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01760	Continued From page 20 been administered because according to the AVS, the order changed on April 24, 2026, but the MAR was not changed until May 18, 2026. Staff documented 12.5 mg was administered when the dose was supposed to be 25 mg. CNS-C stated she is unsure why the folic acid was not on the MAR. CNS-C further stated the staff didn't administer the medications on those days because they did not have them available. CNS-C could not explain why they were documented as administered on May 5, 2026. CNS-C further stated staff should have documented if administered and if not administered should have been documented as such with an explanation. On May 20, 2026, at 8:43 a.m., CNS-C stated, "there is a rule where if less than 50% of the orders changed, you do not need to get new signed orders. The pharmacy receives the order an places them on the MAR." CNS-C then checks to make sure it matches what the provider told her and approves it. The pharmacy did send a copy of the order with the medications and they were in the medication cabinet with the medications; however, they were not routinely checked. The pharmacy reconciles the medications. The licensee's Medication Administration policy dated January 1, 2023, indicated the licensed nurse is responsible for assessing medications to assure that all medications are current and ordered by the prescriber. The licensee's Medication Documentation policy dated January 1, 2023, included the following: - Each medication administered by [license name] staff will be documented in the resident's clinical record. Documentation will be complete, accurate and legible.	01760		

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01760	Continued From page 21 - 1. Complete documentation of medication administration includes the following a. Resident's name b. Medication name c. Medication dosage d. Date and time of administration e. Method/route of administration f. Signature and Title of staff administering the medication 2. If the administration of one or more medications was not completed, staff will document the following a. The reason why the medication was not administered b. Follow up procedures to meet the resident's needs in compliance with the Medication Management Plan c. Appropriate notification to RN Supervisor or other persons as instructed regarding missed dosages d. Medication Error report, if appropriate 4. Documentation of medication administration and medication set up will be completed promptly. The licensee's Prescriptions of medication policy dated January 1, 2023, included: [License name] will administer medications as prescribed by the authorized prescriber 1. [License name] will maintain a current written or electronically recorded prescription for all prescribed medications managed for the resident. 2. The RN or licensed health professional will obtain provider orders or prescriptions for all medications, treatments and therapies. The order will include the following elements: a. Resident information b. Details & description of the medications, treatment or therapy to be provided	01760		

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01760	Continued From page 22 c. Frequency, dose, times, route d. Other pertinent and relevant information" No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for all medications the provider had managed for three of four residents (R2, R3, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a 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: R2	01820		

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01820	Continued From page 23 On May 20, 2026, at 7:16 a.m., the surveyor observed unlicensed personnel (ULP)-D administering medications to R2. The medications included an albuterol inhaler 2 puffs. R2's medication administration record (MAR) dated May 2026, included Albuterol HFA inhale 1-2 puffs by mouth every 4 hours while awake which was being administered and signed off by staff a.m., mid-day, and p.m. The documentation did not indicate if one or two puffs were administered and based on the medication administration times indicated, the medication would not be administered every four hours while awake. R2's physician orders dated February 5, 2026, included albuterol inhaler, inhale 2 puffs every 6 hours as needed for shortness of breath. The orders did not include a scheduled dose of albuterol. On May 20, 2026, at 9:24 a.m., clinical nurse supervisor (CNS)-C stated she did not have an order for R2's scheduled albuterol inhaler and would have to get it from the pharmacy. The administration times for the albuterol was how the pharmacy had entered them into the MAR. No further orders for R2's albuterol was provided R3 On May 20, 2026, at 7:07 a.m., the surveyor observed ULP-D administering medications to R3. R3's MAR dated May 2026, included Senna Concentrate/Docusate Sodium take one tablet by mouth daily for constipation and was signed off daily in the evening.	01820		

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01820	Continued From page 24 On May 20, 2026, at 10:20 a.m., the surveyor observed licensed assisted living director/registered nurse (LALD/RN)-A tearing off the signature page from physician orders, removing a printed medication list from the printer and stapled the signature page to the printed medication list. The surveyor requested the signature page be attached to the original document. LALD/RN-A stated he thought I wanted a current list and reattached the signature page to the original document. R3's physician orders dated February 13, 2026, included docusate sodium/sennosides 1 tablet by mouth twice daily as needed. The orders did not include a scheduled dose. On May 20, 2026, at 10:40 a.m., the surveyor requested a copy of the order for the scheduled Senna/docusate sodium and CNS-C stated she would contact the pharmacy and request it. No further orders were received for R3's scheduled docusate sodium/sennosides. R5 On May 20, 2026, at 1:20 p.m., the surveyor observed licensed assisted living director (LALD)-B administering medications to R5. R5's MAR dated May 2026, included the following: - levothyroxine 112 micrograms (mcg) give one tab by mouth every morning on an empty stomach, and was signed off daily at 8:00 a.m. by staff; - olapatadine eye drops one drop in both eyes daily by self-administration; - fexofenadine 180 milligrams (mg) take one	01820		

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	39541	A. BUILDING: _____ B. WING _____	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALABAMA RESIDENCY	14438 ALABAMA AVENUE SOUTH SAVAGE, MN 55378

(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
01820	Continued From page 25 tablet by mouth daily was scheduled at 8:00 p.m. and was signed daily by staff - cetirizine 10 mg take one tablet every day scheduled at 8:00 a.m. and was signed off daily by staff. R5's physician orders included: - December 18, 2026 - - cetirizine 10 mg take one tablet every day - sucralfate 1 gram before meals and at bedtime - May 15, 2026 - quetiapine 200 mg take one tab by mouth every night R5's record review by the surveyor identified the following discrepancies: - no order for levothyroxine - no order for olapatadine - no order for fexofenadine - duplicate therapy of fexofenadine and cetirizine was being signed off as administered - quetiapine was not on the medication administration record and therefore was not being documented as administered by the staff. On May 20, 2026, at 12:05 p.m., CNS-C stated the quetiapine should have been on the MAR and according to the pharmacy the sucralfate was discontinued in February. CNS-C did not have an order to discontinue as she used the pharmacy. On May 20, 2026, at 1:23 p.m., CNS-C stated she is unsure if the correct dose of Coreg had been administered as according to the AVS, the order changed on April 24, 2026, but the MAR was not changed until May 18, 2026. Staff documented 12.5 mg was administered when the dose was supposed to be 25 mg. CNS-C stated she is unsure why the folic acid was not on the MAR. CNS-C further stated the staff didn't	01820		

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01820	Continued From page 26 administer the medications on those days because they did not have them available. CNS-C could not explain why they were documented as administered then on May 5, 2026. CNS-C stated staff should have documented if administered and if not administered should have been documented as such with an explanation. On May 20, 2026, at 8:43 a.m., CNS-C stated, "there is a rule where if less than 50% of the orders changed, you do not need to get new signed orders." The pharmacy receives the order an places them on the MAR. CNS-C then checks to make sure it matches what the provider told her and approves it. The pharmacy did send a copy of the order with the medications and they were in the medication cabinet with the medications; however, they were not routinely checked. The pharmacy reconciles the medications. The licensee's Medication Administration policy dated January 1, 2023, included the licensed nurse is responsible for assessing medications to assure that all medications are current and ordered by the prescriber. The licensee's Prescriptions of medication policy dated January 1, 2023, included: [License name] will administer medications as prescribed by the authorized prescriber 1. [License name] will maintain a current written or electronically recorded prescription for all prescribed medications managed for the resident. 2. The RN or licensed health professional will obtain provider orders or prescriptions for all medications, treatments and therapies. The order will include the following elements: a. Resident information b. Details & description of the medications,	01820		

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01820	Continued From page 27 treatment or therapy to be provided c. Frequency, dose, times, route d. Other pertinent and relevant information" No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01890 SS=E	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 time sensitive medications were labeled with open and/or expiration dates in the facility's medication cupboard and failed to ensure the medications were stored with a full prescription label or labeled with the resident's name for four of five residents (R2, R3, R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the	01890		

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01890	Continued From page 28 situation has occurred repeatedly; but is not found to be pervasive). The findings include: On May 18, 2026, at 12:31 p.m., the medication cupboard was reviewed by the surveyor with clinical nurse supervisor (CNS)-C and the following was identified: - R2 had two albuterol inhalers - one inhaler did not have a pharmacy label - one inhaler had 5-10 inhalations remaining and did not contain an open date. - R3 had three lidocaine patches loose in a bin without a pharmacy label. There was no corresponding box in the bin. - R4 had Biofreeze which did not contain a pharmacy label and was not marked in any way as belonging to R4. - R5 had refresh eye drops which did not contain a pharmacy label and was not marked in any way as belonging to R5. At this time, CNS-C stated all medications should be labeled with a pharmacy label and over the counter medications should have the resident's name. CNS-C stated time sensitive medications should be labeled with an open date. The licensee's Storage/Control of Medications policy dated January 1, 2023, included the following: 2. Prescription drugs, prior to being set up for immediate or later administration, must be kept in the original container(s) in which they were dispensed by the pharmacy bearing the original prescription label with legible information. 3. The medication is labeled completely and legibly. The medication label should contain the following.	01890		

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01890	Continued From page 29 a. Prescription number and name of medication b. Strength and quantity c. Expiration date for time-dated drugs d. Directions for use e. Resident's name f. Prescriber's name g. Date issued h. Name and address of licensed pharmacy issuing the medication 4. The licensed nurse is responsible for dating time-sensitive medications when opened. 5. Over-the-counter (OTC) medications and dietary supplements that are not prescribed should be retained in their original, labeled container with directions for use. 6. Medications are stored in a secured medication cabinet. Only authorized nursing personnel have access to the locked cabinet. 7. If a sample medication is used, the same package will be labeled with the resident's name and kept with the resident's other medications. The registered nurse is responsible for assuring that there are no contraindications for the medication. Albuterol inhaler prescribing information dated March 2008, indicated it should be discarded when the counter reads 000 (after 200 sprays have been used) or 6 months after removal from the moisture-protective foil pouch, whichever comes first. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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02310	Continued From page 30 (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 three of three residents (R3, R2, R4) with a hospital bed rail. This resulted in an immediate order issued on May 19, 2026. 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 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: R3 On May 19, 2026, at 11:50 a.m., the surveyor observed R3's hospital bed with bed rails. The bed rail was loose and moved significantly back and forth when checking stability. The range of the movement of the bed rail could create entrapment areas under the ends of the rail. R3's Clinical Update Assessment dated April 29, 2026, indicated R3 had an "electric bed" and had 2-sided bed rails and included the following	02310		

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02310	Continued From page 31 measurements: - Zone 1 (space between the rails) - 3.6 inches - Zone 2 (space under the rail, between the rail supports) - 1 inch - Zone 3 (space between the rail and mattress) - 1 inch - Zone 4 (space under the rail at the ends of the rail, between the rail and mattress) - 1 inch On May 19, 2026, at 11:57 a.m., the surveyor observed R3's hospital bed rail with clinical nurse supervisor (CNS)-C. CNS-C stated she was unaware how loose the rail was. CNS-C attempted to tighten the rail without success. CNS-C stated that was just how it was, and the bed rail couldn't be tightened. R3's record lacked: - accurate specific measurements of zones of entrapment; - physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - any necessary information related to interventions to mitigate safety risks. R2 On May 19, 2026, at 11:50 a.m., the surveyor observed R2's hospital bed with bed rails. The bed rail was loose and moved back and forth when grasped. The rail was a single rail support which extended each side and went around and attached to the top rail. The bottom part of the rail did not connect to the support bar. The height of the gap was visibly greater than 4.75 inches. There was approximately a 1 inch gap between the mattress and the bed rail. R2's Clinical Update Assessment dated February 4, 2026, indicated R2 had a standard bed frame	02310		

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02310	Continued From page 32 instead of the hospital bed which was in use and included the following measurements: - Zone 1 - 3.6 inches - Zone 2 - 0 inches "this zone does not exist" - Zone 3 - 0 inches - Zone 4 - 0 inches "this zone does not exist" R2's record lacked: - accurate specific measurements of zones of entrapment; - physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - any necessary information related to interventions to mitigate safety risks. On May 19, 2026, at 11:57 a.m., licensed assisted living director (LALD)-B stated the company who provided the beds checked them, however LALD-B was unsure when they were last checked. On May 19, 2026, at 11:57 a.m., the surveyor observed the hospital bed rail with CNS-C. CNS-C used a tape measure and stated Zone 1 was 4.5 inches, Zone 3 was one inch. CNS-C was unaware the mattress to the top rail zone included the area within the gap. On May 19, 2026, at 12:30 p.m., CNS-C stated R2's rails were original to the bed and could not be tightened and that was just how they are. CNS-C stated the supply company brought the bed that way and there was nothing they could do about it. CNS-C stated she did the assessment every 90 days, and staff checked the rail daily, although there was no documentation. When the surveyor asked why it had not been reported prior, CNS-C stated there was nothing they could do about it. CNS-C further stated, "I don't think it	02310		

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02310	Continued From page 33 is a problem" and "that is how the supply company brought it so how can it be a problem?" R4 On May 19, 2026, at 9:53 a.m., the surveyor observed staff completing morning cares and getting R4 up for the day. The surveyor observed R4 was in a hospital bed with bilateral upper half bed rails. R4's Clinical Update Assessment dated April 29, 2026, indicated R4 had an electric bed with "2-sided bed rail". The following measurements were included: - Zone 1 - indicated yes that area within the rail was less that 4 3/4 inches but did not include an actual measurement. - Zone 2 - 3.5 inches - Zone 3 - 3.3 inches - Zone 4 - indicated yes the area under the rail, at the ends of the rail is less than 2 3/8 inches but did not include an actual measurement R4's record lacked specific measurements of zones 1 and 4 of entrapment. The licensee's Side Rail Use policy dated August 1, 2022, included: - The registered nurse (RN) was responsible to ensure that the bed rails in use were of a safe design and properly maintained. - Bed rails would be used consistent with the manufacturer's recommendations. If the manufacturer's recommendations were not available, the RN would use appropriate nursing judgement related to the implementation of the bed rails. - The need for bed rails would be reassessed and documented as needed, but not less than every 90 days.	02310		

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02310	Continued From page 34 The March 10, 2006, United States Food and Drug Administration (FDA) Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (space between the rails), zone 2 (space under the rail, between the rail supports) zone 3 (space between the rail and mattress), should be less than 4 and 3/4 inches. Zone 4 (space under the rail at the ends of the rail, between the rail and mattress) should be less than 2 and 3/8 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." The MDH website, Assisted Living Resources & FAQs last updated March 9, 2026, indicated licensees should refer to individual manufacturer's guidelines for appropriate installation, maintenance and use. To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without	02310		

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02310	Continued From page 35 assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint. Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - Specific measurements of zones of entrapment; - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE The licensee took immediate action to mitigate risk; however, the scope and level remains at l.	02310		
02320 SS=D	144G.91 Subd. 4 (b) 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.	02320		

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02320	Continued From page 36 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one unliensed personnel (ULP-D) administered medications according to policy and accepted standards of practice. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On May 20, 2026, at 7:16 a.m., the surveyor observed ULP-D administering medications to R2, including an albuterol inhaler. ULP-D asked R2 to raise her finger when she was ready. When R2 raised her finger, ULP-D administered the dose. ULP-D stated again to raise her finger and R2 raised her finger immediately and ULP-D gave the second inhalation. ULP-D did not wait at least one minute between inhalations and ULP-D did not offer water to R2 to rinse and spit, nor did ULP-D cue or assist R2 to rinse and spit. R2's physician orders dated February 5, 2026, included albuterol inhaler, inhale 2 puffs every 6 hours as needed for shortness of breath. The orders did not include a scheduled dose of albuterol. On May 20, 2026, at 11:39 a.m., clinical nurse	02320		

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02320	Continued From page 37 supervisor (CNS)-C stated staff were trained to wait one minute in between inhalations and staff should have assisted R2 to rinse her mouth after using the inhaler. The prescribing information for albuterol HFA inhaler dated November 2024, included: - If your doctor has prescribed additional puffs, wait one minute, shake the inhaler again and repeat. The licensee's Inhaler Administration policy dated January 1, 2023, included the the following: - Wait 30-60 seconds between puffs if more than one puff is ordered - After Administration - instruct resident to rinse mouth and spit out water. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

ALABAMA RESIDENCE
14438 ALABAMA AVENUE SOUTH
Savage, MN 55378
Scott County
Parcel:

Phone:

License Info

License: HFID 39541

Risk:
License:
Expires on:
CFPM: Batulo M. Maolin
CFPM #: FM108666; Exp: 09/16/2027

Inspection Info

Report Number: F1047261128
Inspection Type: Full - Single
Date: 5/19/2026 Time: 10:00 am
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

Inspection conducted with B. Moalin and reviewed with MDH Nurse Evaluator S. Haag.

The establishment has a residential kitchen and serves food that is prepared that day. The kitchen has wood cabinets, wood floors, painted walls, solid counter top, & a painted ceiling.

A two basin sink is located in the kitchen. One sink basin is designated for hand washing. A residential dish machine is located in the kitchen.

Discussed hand washing,w are washing, staff illness policy, temperature control, final cook temperatures, cleaning/sanitizing procedures, serving high susceptible populations, & food handling procedures.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1047261128 from 5/19/2026

Batulo M. Maolin
Operator

Holly Sievers,
Public Health Sanitarian 3
651-201-5946
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Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Establishment Info

ALABAMA RESIDENCE
Savage
County/Group: Scott County

Inspection Info

Report Number: F1047261128
Inspection Type: Full
Date: 5/19/2026
Time: 10:00 am

Food Temperature: Product/Item/Unit: Milk**; Temperature Process:** Cold-Holding
Location: Refrigerator at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Cheese**; Temperature Process:** Cold-Holding
Location: Refrigerator at 39 Degrees F.
Comment:
Violation Issued?: No

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Sanitizer Observations/Recordings

Establishment Info

ALABAMA RESIDENCE
Savage
County/Group: Scott County

Inspection Info

Report Number: F1047261128
Inspection Type: Full
Date: 5/19/2026
Time: 10:00 am

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Greater Than** 160 Degrees F.
Comment: per operator log
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL39541016-0	**Date:** May 20, 2026
Facility Name: ALABAMA RESIDENCE	
Facility Address: 14438 ALABAMA AVE S, SAVAGE, MN 55378	

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Two (2) days

1. Smoke alarms are provided outside and in immediate vicinity of each room used for sleeping purposes. [Minn. Stat. 144G.45 subd.2]

   Comments: Facility failed to provide a smoke alarm outside bedrooms 2 and 3, there was an alarm mounting plate in the area but the alarm was missing.

2. Smoke alarms interconnected so that actuation of one alarm causes all alarms in the individual dwelling or sleeping unit to operate where more than one smoke alarm is required within an individual dwelling or sleeping unit. [Minn. Stat. 144G.45 subd.2]

   Comments: Smoke alarms were not interconnected when tested.

3. Smoke Alarm power supply complies with MN State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated. [Minn. Stat. 144G.45 subd.2]

   Comments: The existing hardwired smoke alarms were removed from resident bedrooms 3 and 5, they were replaced with battery powered smoke alarms. Existing hardwired smoke alarms are required to be maintained as installed previously and shall be replaced with smoke alarms having the same type of power supply.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. [Minn. Stat. 144G.45 subd.2]

   Comments: The main level bathroom exhaust fan was not working and there was peeling paint around the fan cover.

   On the master bath ceiling and in the laundry room, the ceiling had peeling paint.

   The kitchen ceiling had a large area of missing paint.

   In bedroom 5, the ceiling had peeled paint and an old water stain.

   Missing or peeled paint in these areas allows moisture to gather and potentially create a mold issue it also can deteriorate the drywall and weaken the fire barrier.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

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1. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include the location and number of resident rooms. [Minn. Stat. 144G.45 subd.2]

   Comments: The evacuation plans lacked accurate identification of the facility layout. Exit plan diagrams must be correctly labeled to reduce confusion for emergency responders and potential obstructions for egress in a fire or similar emergency.

2. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

   Comments: The licensed assisted living director/ registered nurse *(LALD/RN)-A lacked documentation that showed training was provided to employees on the FSEP upon hire and at least twice per year.*