



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 22, 2025

Licensee

Autumn Cottages by Knute Nelson
812 McKay Avenue South
Alexandria, MN 56308

RE: Project Number(s) SL30736016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 20, 2025, 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 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.

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$500.00**. 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. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in cursive script that reads "Jessie Chenze". The ink is dark and the signature is fluid, with the first and last names being more prominent than the middle name.

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30736	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/20/2025
NAME OF PROVIDER OR SUPPLIER AUTUMN COTTAGES BY KNUTE NELSON			STREET ADDRESS, CITY, STATE, ZIP CODE 812 MCKAY AVENUE SOUTH 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 ***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: SL30736016-0 On May 19, 2025, through May 20, 2025, 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 14 residents; 14 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480			

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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, 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated May 19, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480			

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480			
0 510 SS=E	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 infection control program to comply with accepted health care, medical, and nursing standards for infection control for two of five employees (unlicensed personnel/ULP-D, ULP-F). 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).	0 510			

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0 510	Continued From page 4 The findings include: On May 20, 2025, at 7:20 a.m., the surveyor observed ULP-D assist R2 in the bathroom. With gloved hands, ULP-D provided perineal cares to R2, pulled up R2's brief and pants, assisted R2 to the wheelchair and touched the wheelchair handle. At this time, ULP-D removed the gloves, opened the bathroom door, and pushed R2 to the dining room in his wheelchair. ULP-D then opened the gate in the kitchen and washed her hands at the sink. On May 20, 2025, at 10:40 a.m., ULP-D stated she was trained to put gloves on anytime she touched a resident, but was not sure about training on removing gloves and doing hand hygiene between gloves. On May 20, 2025, at 9:15 a.m., the surveyor observed ULP-F assist R1 in the bathroom. With gloved hands, ULP-F assisted R1 to stand with a standing lift, lowered R1's pants and brief, and provided perineal cares to clean up bowel incontinence prior to sitting on the toilet. R1 was then lowered to the toilet. ULP-F then pushed the call light in the bathroom to call other staff, opened the bathroom door, took a bag of trash from a peer, and asked the peer to bring clean pants for R1. ULP-F then changed gloves without performing hand hygiene, and got the new pants from the peer at the door, removed the lift sling and pushed the lift back away from R1, removed the soiled pants, placed a new brief and liner, and put on new pants and shoes. ULP-F then placed the lift, turned it on, and moved R1 to a standing position. At this time, performed perineal cares, changed gloves and provided a brief from the closet to a peer outside. R1 was then placed in the wheelchair and the sling was removed. At this	0 510			

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0 510	Continued From page 5 time, ULP-F removed the gloves and washed her hands in the sink. On May 20, 2025, at 10:15 a.m., ULP-F stated she should have changed gloves before providing a brief to a peer for another resident. In addition, ULP-F stated she should have performed hand washing between gloves and after doing perineal cares. On May 20, 2025, at 11:30 a.m., clinical nurse supervisor (CNS)-A stated staff are expected to do hand hygiene after perineal cares and after removing gloves. The licensee's Hand Hygiene policy dated November 1, 2021, noted hands should be washed when moving between a contaminated body site to a clean body site and after removing gloves. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting	0 550			

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0 550	Continued From page 6 suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place, information about the facility's grievance procedure with the required content. This had the potential to affect the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: During the facility tour on May 19, 2025, at 10:15 a.m., with clinical nurse supervisor (CNS)-A, registered nurse (RN)-C, and regional director of operations (RDO)-I, the surveyor observed the building to be an open building with two sides, lake and country, with resident rooms on each side. It included a large common area for residents to watch television, have activities, and gather. The main entrance had postings hanging. The licensee's undated Complaint Resolution &	0 550			

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0 550	Continued From page 7 Grievances posting lacked the email contact information for the person responsible for handling resident grievances and the contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities. On May 20, 2025, at 1:55 p.m., licensed assisted living director (LALD)-B stated the above required content was missing from the posted form. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include:	0 775			

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0 775	Continued From page 8 On a facility tour on May 20, 2025, at 2:45 p.m., with maintenance technician (MT)-C, the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: There was a controlled egress locking system installed on the two emergency exit doors in the front of the building. These exit doors require a key card to unlock these doors. The controlled egress door locking system was not provided with a device capable of deactivating the delayed egress door hardware to the unlocked position from the nurse station or other approved location for occupants to exit in the event of an emergency. The controlled egress locking system is required to be provided with a switch or device located at the nurse station or other approved location to deactivate the delayed egress locked exit doors for building occupants to exit in the event of an emergency. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775			
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the	01060			

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01060	Continued From page 9 facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the	01060			

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01060	Continued From page 10 required content for an emergency relocation to the resident, legal representative, and designated representative for one of one resident (R1) who was hospitalized. 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 Alzheimer's disease, anxiety disorder, and hypertension. R1's Resident Service Plan dated December 16, 2021, indicated R1 received services including assistance with medication administration, bathing, dressing, and hygiene. R1's record contained a Notification of Emergency Relocation dated February 6, 2025. The notice indicated R1 was sent to the ER (emergency room). However, it lacked the name and contact information for the location to which the resident had been relocated. On May 20, 2025, at 11:05 a.m., clinical nurse supervisor (CNS)-A stated R1 had been sent to the Alexandria hospital, the only option in town, and said the form did not include the name or contact information. No further information provided.	01060			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER AUTUMN COTTAGES BY KNUTE NELSON			STREET ADDRESS, CITY, STATE, ZIP CODE 812 MCKAY AVENUE SOUTH 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
01060	Continued From page 11	01060			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service	01650			

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01650	Continued From page 12 plan included the correct required content for two of two residents (R1, 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 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: R1 R1's diagnoses included Alzheimer's disease, anxiety disorder, and hypertension. On May 20, 2025, at 9:15 a.m., the surveyor observed unlicensed personnel (ULP)-F assist R1 in the bathroom. R1's Resident Service Plan dated December 16, 2021, indicated R1 received services including assistance with medication administration, bathing, dressing, and hygiene. However, it lacked a contingency plan including: - 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. R2 R2's diagnoses included Parkinson's disease, dementia, and bipolar disorder. On May 20, 2025, at 7:20 a.m., the surveyor observed ULP-D assist R2 in the bathroom.	01650			

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01650	Continued From page 13 R2's Resident Service Plan dated January 8, 2025, indicated R2 received services including assistance with medication administration, oxygen management, and grooming. However, it lacked a contingency plan including: - 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. On May 20, 2025, at 11:30 a.m., registered nurse (RN)-C stated the above required information was not included on the service plan for any resident. The licensee's Contents of Service Plans policy dated January 20, 2023, noted the service plan would include a contingency plan including the circumstances in which emergency medical services are not to be summoned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state	01910			

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01910	Continued From page 14 and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one resident (R3) upon discharge. 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: R3 discharged to her home on April 8, 2025. R3's diagnoses included obesity, anxiety, and osteoporosis. R3's record included a Discharge Summary dated April 8, 2025, which noted R3 discharged to home. It noted under medication disposition "All comfort meds [medications] sent with residnet (sic) home: Morphine 29 tabs [tablets] Ativan 30	01910			

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01910	Continued From page 15 tabs Atropine 1 bottle volaren gel- 1.5 tubes Lantropost 1/2 bottle." R3's Discharge Medication Form dated April 8, 2025, noted: - Morphine 5 milligrams (mg) solutab - 1 tab by mouth 29 tabs; - Ativan 0.25 mg solutab - 30 tabs; and - Atropine drops - new bottle. R3's record lacked a disposition of medications to include: - the prescription number. R3's Resident Service Plan dated October 16, 2023, indicated R3 received services including assistance with medication administration, bathing, and dressing. On May 20, 2025, at 11:00 a.m., registered nurse (RN)-C stated the prescription number was not included on the forms provided and would look to see if it was on any other form sent out with the resident. However, no further information was received. The licensee's Disposition or Disposal of Medication policy dated October 29, 2021, noted unused controlled substances may be given to a resident or resident's representative upon transfer and instructed staff to document the release including the prescription number. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			

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01930	Continued From page 16	01930			
01930 SS=F	144G.72 Subd. 2 Policies and procedures (a) An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines. (b) The written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting treatment or therapy activities, educating and communicating with residents about treatments or therapies they are receiving, monitoring and evaluating the treatment or therapy, and communicating with the prescriber. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain current written treatment management policies and procedures under the supervision and direction of a registered nurse (RN). 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).	01930			

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01930	Continued From page 17 The findings include: During the entrance conference on May 19, 2025, at 9:50 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided treatment management services to the licensee's residents. The licensee's provided policies lacked: - educating residents about treatments or therapies they are receiving. On May 20, 2025, at 10:45 a.m., CNS-A stated the policy would be provided. However, no information was received. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01930			
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the	02040			

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02040	Continued From page 18 licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment with mitigation factors on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on May 20, 2025, at 2:35 p.m., with licensed assisted living director (LALD)-B on the hazard vulnerability assessment for the physical environment of the facility. Record review indicated that the licensee had not performed a hazard vulnerability assessment with risk and mitigation factors on and around the property. During interview, LALD-B stated that the licensee had performed a hazard assessment for the Appendix Z requirements but had not performed a hazard vulnerability assessment for the physical environment on or around the property. The hazard vulnerability assessment should include the risks factors and what the facility plans to do for a mitigation process. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040			

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02110	Continued From page 19	02110			
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in.	02110			

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02110	Continued From page 20 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures required in the licensing of assisted living facilities with dementia care were provided to each resident and the residents' legal and designated representative at the time of move-in. 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, 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 with Dementia Care license issued on November 15, 2024. On May 20, 2025, at 11:30 a.m., registered nurse (RN)-C stated the licensee did not provide the policies to residents or their representatives. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110			



Fergus Falls District Office
Minnesota Department of Health
2312 College Way
Fergus Falls , MN 56537
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info	License Info	Inspection Info
Autumn Cottages 812 McKay Avenue South Alexandria, MN 56308 Douglas County Parcel: Phone:	License: HFID 30736 Risk: License: Expires on: CFPM: Amber Knapper CFPM #: 12331; Exp: 5/16/2027	Report Number: F7935251006 Inspection Type: Full - Single Date: 5/19/2025 Time: 3:33:14 PM Duration: minutes Announced Inspection: No <u>Total Priority 1 Orders: 0</u> <u>Total Priority 2 Orders: 1</u> <u>Total Priority 3 Orders: 0</u> <u>Delivery: Emailed</u>

New Order: 4-300 Equipment Numbers and Capacities

4-302.13A *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0710A Provide a readily accessible temperature measuring device for measuring the washing and sanitizing temperatures in manual warewashing operations.
COMMENT: Need a max/min thermometer or test strips to check that dish machine gets up to proper temp for sanitizing.
Comply By: 5/19/2025 Originally Issued On: 5/19/2025

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 Fergus Falls District Office inspection report number F7935251006 from 5/19/2025

Rebecca Tonneson

Establishment Representative

Rebecca Tonneson, RS
Public Health Sanitarian Supervisor
218-332-5142
rebecca.tonneson@state.mn.us



Fergus Falls District Office
Minnesota Department of Health
2312 College Way
Fergus Falls , MN 56537

Temperature Observations/Recordings

Page: 1

Establishment Info	Inspection Info
Autumn Cottages	Report Number: F7935251006
Alexandria	Inspection Type: Full
County/Group: Douglas County	Date: 5/19/2025
	Time: 3:33:14 PM

Food Temperature: **Product/Item/Unit:** Beef; **Temperature Process:** Cooking

Location: Oven at 177 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Peas; **Temperature Process:** Cooking

Location: Oven at 169 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Mashed Potatoes; **Temperature Process:** Cooking

Location: Oven at 171 Degrees F.

Comment:

Violation Issued?: No