Electronically Delivered

January 6, 2025

Licensee
Alliance Homes Corporation
4946 Jackson Street Northeast
Columbia Heights, MN 55421

RE: Project Number(s) SL35585015

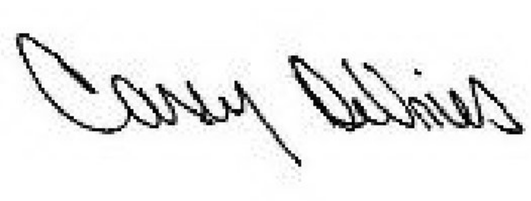
Dear Licensee:

On November 25, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the September 25, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

JMD

Electronically Delivered

October 28, 2024

Licensee
Alliance Homes Corporation
4946 Jackson Street Northeast
Columbia Heights, MN 55421

RE: Project Number(s) SL35585015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 25, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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:

1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. 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. 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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35585	A. BUILDING: _____ B. WING _____	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIANCE HOMES CORPORATION	4946 JACKSON STREET NE COLUMBIA HEIGHTS, MN 55421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL35585015-0 On September 23, 2024, through September 25, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were three residents; three receiving services under the Assisted Living Facility license. An immediate correction order was issued on September 24, 2024, for tag identification number 1290. During the course of the survey, the licensee took action to mitigate the immediate risk. Noncompliance remained and the scope and level remain unchanged.	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 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 23, 2024, 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 to the FBEIR for any compliance dates.	0 480		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual	0 650		

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0 650	Continued From page 2 contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the employee record contained the required content for two of two employees (unlicensed personnel (ULP)-B, clinical nurse supervisor/assisted living director (CNS/ALD)-A). 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).	0 650		

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0 650	Continued From page 3 The findings include: ULP-B On September 24, 2024, between 8:50 a.m. and 9:10 a.m., the surveyor observed ULP-B administer medications to R1 and R2. ULP-B was hired on August 20, 2024, to provide assisted living services to all residents. ULP-B's training record included Home Health Aide (HHA) Supervision: Medication Management dated August 30, 2024, which indicated CNS/ALD-A observed ULP-B to be competent on tasks related to R2. ULP-B's record lacked competency on the following nursing delegated tasks to include: - all medication administration route procedures; - preparing medications for unplanned times away; and -administration of compression stockings. On September 24, 2024, at 1:57 p.m., CNS/ALD-A stated she used the HHA Supervision: Medication Management form as documentation of competency on medication administration because she felt it was appropriate. CNS/ALD-A stated ULP-B and other ULPs completed compression sock training and competency but she did not have documentation for anyone. On September 24, 2024, at 2:15 p.m., CNS/ALD-A stated she trained all staff how to prepare medications for unplanned times away and explained the instruction she gave staff. CNS/ALD-A did not have documentation of training and competency on that task.	0 650		

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0 650	Continued From page 4 CNS/ALD-A CNS/ALD-A was hired November 11, 2022, to provide assisted living services to residents, supervision of staff, and managerial duties for the licensee. CNS/ALD-A's employee record lacked documentation of an annual performance review, and documentation of reviewing provider's policies and procedures. On September 24, 2024, at 2:48 p.m., CNS/ALD-A stated the on-call registered nurse (RN)-E completed her review July 2024, but didn't document it on the licensee's electronic health record (RTasks). The licensee's Personnel Records policy effective August 1, 2021, indicated, "A record of each paid employee, regularly scheduled volunteer providing assisted living services, and each individual contractor providing assisted living service for [licensee] will be maintained." The policy also indicated at a minimum, all documents related to the following are kept in the personnel record, as applicable to job requirements: -documentation of orientation; -performance reviews; and -competency evaluations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a	0 660		

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0 660	Continued From page 5 comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which includes baseline testing for two of two employee (unlicensed personnel (ULP)-B, clinical nurse supervisor/assisted living director (CNS/ALD)-A). The license also failed to ensure a baseline TB screening tool for healthcare workers was completed for one of two employees (ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 660		

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0 660	Continued From page 6 The findings include: The facility TB risk assessment was completed January 27, 2024, and indicated the facility was at a low risk for TB transmission. On September 23, 2024, through September 15, 2024, the surveyor observed ULP-B provide supervision, meals, medication administration and housekeeping. The surveyor observed CNS/ALD-A provide direction to ULP-B, and medication management. ULP-B ULP-B was hired on August 20, 2024, to provide services to residents. ULP-B's employee record included a chest x-ray (CXR) completed on August 12, 2024. ULP-B's employee record lacked documentation of refusal of both the two-step tuberculin skin test (TST) and interferon-gamma release assays (IGRAs), followed by CXR with provider evaluation, and completed consent and release for TB screening. CNS/ALD-A CNS/ALD- was hired on November 11, 2022, to provide supervision of licensee's employees and residents. CNS/ALD-A's employee record included a consent and release for TB screening and a completed CXR both dated November 11, 2022. CNS/ALD-A employee record lacked documentation of refusal of both the two-step tuberculin skin test (TST) and interferon-gamma release assays (IGRAs), followed by CXR with	0 660		

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0 660	Continued From page 7 provider evaluation. On September 24, 2024, at 11:30 a.m., CNS/ALD-A stated she had a TB vaccine and had a bad reaction to the two-step skin test (TST), so her provider told her to complete CXR instead of TST. CNS/ALD-A did not have a provider evaluation or documentation of refusal of TST or TB blood test to go with the CXR. CNS/ALD-A stated she was unaware of the requirement. On September 24, 2024, at 12:00 p.m., CNS/ALD-A stated she would ask ULP-B if she had a provider evaluation and documentation of refusal of two-step skin test (TST) or TB blood test. CNS/ALD-A stated she did not have a completed consent and release for TB screening for ULP-B. CNS/ALD-A provided ULP-B's completed consent and release for TB screening dated September 24, 2024. The Minnesota Department of Health's Assisted Living Resources & Frequently Asked Questions (FAQs) last updated on April 3, 2024, indicated "A CXR alone is not acceptable documentation. You either need -documentation of a positive two-step Tuberculin Skin Test (TST) or Interferon-Gamma Release Assay test (IGRA), and -a CXR with provider evaluation after that date Or -documentation of refusal of both the two-test TST and IGRA -followed by a new CXR and provider evaluation." The licensee's Tuberculosis Screening/Prevention policy dated August 1, 2021, indicated if staff provide written documentation of the results of a chest x-ray indicating no active TB disease that is dated after	0 660		

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0 660	Continued From page 8 the date of the positive TST or TB blood test result, they do not need another chest x-ray at the time of hire. If staff with a verbal, but undocumented, history of previous positive TST or blood test, will undergo the same screening process as those without previous positive results. Staff should be encouraged to keep copies of the results of the TB screening, for future use. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are	0 680		

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0 680	Continued From page 9 allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required components included in Appendix Z and failed to post the EPP prominently. This had the potential to affect all residents, staff, and visitors during an emergency. 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: The licensee's EPP dated 2021, lacked an individualized plan to include all the required content below: -maintain and annual EP updates: -failure to document the quarterly review of Missing Resident Plan; -process for EP collaboration: -process for cooperation/collaboration with local, tribal, and regional EP; -procedures for tracking of staff and patients: -develop P/P for system to track the location of on-duty staff and sheltered residents; -policies and procedures including evacuation:	0 680		

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0 680	Continued From page 10 -transportation and identification of evacuation location(s); -develop P/P (policies/procedures) to address system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; -develop P/P that must address: use of volunteers, including the process/role for integration; -develop P/P that must address: development with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents; -develop P/P to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; -communication plan must include: method for sharing information and medical documentation for residents under the facility's care, as necessary with other health care providers (HCPs) to maintain continuity of care; -communication plan must include all of the following: means to providing information about the facility's occupancy needs, and it's ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee; -emergency prep testing requirements; -participate in an annual full-scale exercise that is community based OR conduct an annual, individual, facility-based functional exercise OR if the facility experiences an actual emergency requiring activation of plan, facility is exempt from engaging in its next required full-scale exercise; -conduct an additional annual exercise that may include: a second full-scale exercise that is community-based or an individual, facility based functional exercise OR mock disaster drill OR table-top exercise; and -analyze the facility's response to and maintain	0 680		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIANCE HOMES CORPORATION	4946 JACKSON STREET NE COLUMBIA HEIGHTS, MN 55421

(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
0 680	Continued From page 11 documentation of all drills, tabletop exercises and emergency events & revise plan as needed. On September 23, 2024, at 1:00 p.m., clinical nurse supervisor/assisted living director (CNS/ALD)-A stated the EPP was kept downstairs but staff knew where to find it. CNS/ALD-A was unaware the EPP needed to be posted prominently. On September 25, 2024, at 10:36 a.m., CNS/ALD-A explained how she trained staff on how to shut the water off, handle weather problems, and what to do during a fire. She stated she had not documented those trainings. She stated she was not aware of the required content and was given the EPP from the previous assisted living director. CNS/ALD-A stated she included the police station and the YMCA as alternate locations in EPP thinking the residents would be there for a short period of time. CNS/ALD-A didn't think about long-term alternate locations. The licensee's Emergency Preparedness policy effective August 1, 2021, read [licensee] will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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 12 (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 and interview, the licensee failed to provide smoke alarms that are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate and keep the facility in compliance with the Minnesota Fire Code. The deficient conditions has the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 780		

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0 780	Continued From page 13 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: On facility tour with the clinical nurse supervisor/assisted living director (CNS/ALD)-A on September 24, 2024, between 12:45 p.m. and 2:00 p.m. the following deficient conditions were observed: SMOKE ALARMS: The surveyor observed that the smoke alarms outside the resident rooms in the lower level were not interconnected with the rest of the smoke alarms in the facility. The surveyor explained to the CNS/ALD-A that all the smoke alarms in the facility shall be interconnected so when one sounds, they all sound. CEILING: The surveyor observed personal items blocking the emergency escape and rescue opening in resident room 4. There was also vegetation outside this opening blocking the full use of the window. The surveyor explained to the CNS/ALD-A that the emergency escape window shall be useable and operational at all times. These deficient conditions were visually verified by the CNS/ALD-A accompanying on the tour.	0 780		

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0 780	Continued From page 14 TIME PERIOD FOR CORRECTION: Seven (7) 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 and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. 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, 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: On facility tour with the clinical nurse supervisor/assisted living director (CNS/ALD)-A	0 800		

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0 800	Continued From page 15 on September 24, 2024, between 12:45 p.m. and 2:00 p.m. the following deficient conditions were observed: The surveyor observed water stains on the ceiling in the garage and in the kitchen of the facility. The ceiling was deteriorating. The surveyor explained to the CNS/ALD-A that the facility shall be kept in good repair and that all the items noted above shall be fixed. The deficient conditions were visually verified by the CNS/ALD-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.	0 810		

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0 810	Continued From page 16 (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and the annual training on the fire safety and evacuation plan was not being completed for residents and documented semi-annually for employees. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: A record review and interview were conducted on September 24, 2024, at approximately 1:30 p.m.	0 810		

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0 810	Continued From page 17 with the clinical nurse supervisor/assisted living director (CNS/ALD)-A on the fire safety and evacuation plan and training records for the facility. FIRE/EVACUATION PLAN: During record review the CNS/ALD-A stated they do not have a signed contract with a transportation company or contracts for the location they plan to move to if the facility needed to evacuate. TRAINING: During record review the CNS/ALD-A could not provide any documentation that training on the fire safety and evacuation plan had been completed for employees or residents. DRILLS: During record review the CNS/ALD-A provided written documentation showing the drills had been completed but they were completed with overlapping shifts. The surveyor explained to the CNS/ALD-A that a written signed agreement shall be in place with a transportation company and shall be updated annually. Training on the fire safety and evacuation plan shall be provided for employees upon hire and twice a year thereafter and offered to the residents once a year and documented. Drills shall be completed during the shifts and with only the number of employees on said shift. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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0 970	Continued From page 18	0 970		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language that waived the licensee's liability for the health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 23, 2024, at 12:50 p.m., clinical nurse supervisor/assisted living director (CNS/ALD)-A provided the licensee's blank assisted living contract dated April 2020, and stated this contract was most likely the one the residents used. CNS/ALD-A later provided R1's contract which was dated 2021 and stated R1's	0 970		

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0 970	Continued From page 19 contract was the most current one and the one being used for all residents. R1's 2021 [licensee] Assisted Living Contract indicated under Indemnification read, "[licensee] shall not be liable for any damage or injury to the resident ... or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold [licensee] harmless for any claims or damages solely by negligence of [licensee]." On September 25, 2024, at 12:20 p.m., CNS/ALD-A stated she read it as licensee was waiving the responsibility for something they were not responsible for such as something not listed on the care plan. CNS/ALD-A stated she did not read it as a waiver of liability. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01060 SS=F	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 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;	01060		

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01060	Continued From page 20 (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 required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation for one of one resident (R3). This practice resulted in a level two violation (a	01060		

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01060	Continued From page 21 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: R3's diagnoses included schizophrenia (mix of hallucinations, delusions, and disorganized thinking/behavior), bipolar disorder (extreme mood swings), and diabetes mellitus (impaired ability to produce or respond to insulin to maintain sugar levels). R3's Service Plan dated September 1, 2024, noted services including assistance with medication administration, blood glucose monitoring, activities of daily living, and safety. R3's Progress Notes indicated the following hospitalizations dated: - September 1, 2024, through September 2, 2024; and - September 9, 2024, and did not return before end of survey. R3's record lacked evidence of a written notice provided to the resident, the resident's legal representative, and designated representative that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the OOLTC; - if known and applicable, the approximate date	01060		

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01060	Continued From page 22 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 - 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. In addition, the resident's record lacked documented evidence the OOLTC had been notified of a hospitalization longer than four days. On September 24, 2024, at 11:10 a.m., clinical nurse supervisor/assisted living director (CNS/ALD)-A stated she was not aware of the requirement to provide the emergency relocation information to the resident, the resident's representative, and legal representative, and added she was not aware of the requirement to provide written notice to the OOLTC for hospitalizations longer than four days. CNS/ALD-A found a form the license could use going forward. The licensee's Discharge and Transfer of Residents policy dated August 1, 2021, noted in the event of an emergency relocation, the facility would provide a written notice as soon as possible to the resident, legal representative and designated representative, and if the resident had not returned within four days, a copy would be provided to the OOLTC. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		

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01290	Continued From page 23	01290		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure current employee records contained all the required content to include a background study (BGS) clearance letter for one of three employees (unlicensed personnel (ULP)-C). This had the potential to affect all residents living within the facility. 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).	01290		

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01290	Continued From page 24 The findings include: The licensee's current undated employee roster indicated ULP-C was hired on June 6, 2024, to provide assisted living services to residents. A NETStudy 2.0 employee roster from the NETStudy 2.0 website dated September 24, 2024, at 9:32 a.m., did not show ULP-C on the roster and affiliated with licensee. ULP-C's Person Summary on the NETStudy 2.0 website dated September 24, 2024, at 9:42 a.m., read the BGS was submitted on June 3, 2024, and ULP-C was listed as separated on June 18, 2024. Thus, ULP-C had no cleared BGS after that time. On September 24, 2024, at 9:55 a.m., clinical nurse supervisor/assisted living director (CNS/ALD)-A provided the surveyor with an undated staff schedule indicating everyone had set days/hours they worked every week and that the schedule did not change. The schedule indicated ULP-C was scheduled to work every Monday, Tuesday, Wednesday, and Thursday on the overnight shift (8 p.m. to 8 a.m.). CNS/ALD-A stated ULP-C worked last night (Monday overnight) and was scheduled to work tonight (Tuesday overnight). CNS/ALD-A stated overnight staff work alone, thus do not have continuous, direct supervision of an individual with a cleared BGS. On September 24, 2024, at 11:10 a.m., CNS/ALD-A stated administrator (A)-D was responsible for completing BGS for all employees as she had not taken on that role yet. CNS/ALD-A stated ULP-C did complete finger printing but did not know the BGS results.	01290		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01290	Continued From page 25 The NETStudy 2.0 System User Manual updated November 30, 2022, defined continuous, direct supervision - an individual is within sight or hearing of the program's supervising individual to the extent that the program's supervising individual is capable at all times of intervening to protect the health and safety of the persons served by the program. Direct contact services - providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the entity. The manual further defined supervision status - study subjects must be under continuous, direct supervision until the study subject is determined eligible of until the entity is notified by the Department of Human Services (DHS) that the study subject may provide unsupervised services while the background study is being completed. The supervision status is shown in the "Supervision Required" column for convenience. However, programs are instructed to rely on background study notices for supervision status and other background study determination information. The licensee's Recruitment and Hiring policy dated August 1, 2021, indicated the employment process included a background study using NETStudy 2.0 or current version. No further information provided. TIME PERIOD FOR CORRECTION: Immediate During the course of the survey, the licensee took action to mitigate the immediate risk. Noncompliance remained and the scope and level remain unchanged.	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35585	A. BUILDING: _____ B. WING _____	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIANCE HOMES CORPORATION	4946 JACKSON STREET NE COLUMBIA HEIGHTS, MN 55421

(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
01560	Continued From page 26	01560		
01560 SS=C	144G.64 (a, b, c) TRAINING IN DEMENTIA CARE REQUIRED (5) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who requested it, a complete description of the dementia care training program to include person-centered planning and service delivery. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	01560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35585	A. BUILDING: _____ B. WING _____	09/25/2024

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ALLIANCE HOMES CORPORATION	4946 JACKSON STREET NE COLUMBIA HEIGHTS, MN 55421

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01560	Continued From page 27 The findings include: The licensee provided services under an assisted living license. On September 25, 2024, at 12:20 p.m., a request was made for a copy of the description of the training program for dementia care. On September 25, 2024, at 12:21 p.m., clinical nurse supervisor/assisted living director (CNS/ALD)-A began explaining how staff were trained in dementia care then asked if licensee's dementia training policy was what the surveyor was requesting. CNS/ALD-A stated the licensee did not have one available but would create one to make available. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01560		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35585	A. BUILDING: _____ B. WING _____	09/25/2024

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ALLIANCE HOMES CORPORATION	4946 JACKSON STREET NE COLUMBIA HEIGHTS, MN 55421

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01730	Continued From page 28 diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for 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	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35585	A. BUILDING: _____ B. WING _____	09/25/2024

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01730	Continued From page 29 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: R2 admitted to the licensee on September 16, 2022, and began receiving assisted living services. R2's Assessment by Date (nursing assessment) dated September 1, 2024, assessed R2 required assistance with medication management and delegated medication administration to unlicensed personnel (ULP). On September 24, 2024, at 9:02 a.m., ULP-B held a bubble pack that included a label indicating R2's name, date, time, and contents of the bubble pack (1-metformin 500 milligram (mg) extended release (ER) (for weight loss), and 1-topiramate 15 mg (for weight loss)). When ULP-B opened the package, there were three tablets of metformin and one tablet of topiramate. Clinical nurse supervisor/assisted living director (CNS/ALD)-A observed the pharmacy label and said metformin should have been labeled with 3 tablets, but no one brought that to her attention. CNS/ALD-A stated she manually entered in the details of each medication in the electronic medication administration record (eMAR) and was still learning the program. The surveyor stated the eMAR should list the strength of each tablet, not the total ordered dose. CNS/ALD-A confirmed the strength confusion and stated she must have missed entering in the "mg." R2's eMAR was later updated to include the correct information.	01730		

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01730	Continued From page 30 R2's unsigned medication list obtained from R2's electronic health record portal indicated metformin 500 mg ER tablet-take 3 tablets by mouth every evening. R2's Med Admin Summary - Month (eMAR) dated September 1, 2024, through September 24, 2024, included scheduled metformin (oral medication that lowers blood glucose) 1500-give by mouth at 8:00 a.m. The document lacked specific resident instruction on the following: - metformin strength was ordered as 500 milligrams (mg) per tablet but on the MAR, it indicated a strength of 1500 and did not indicate how many tablets R2 should have received. The licensee's Medication Management policy dated August 1, 2021, read, " 6. All staff with responsibility for medication administration have access to information about the medication being administrated, including but not limited to: a. Purpose b. Dosage c. Route d. Frequency e. Instructions related to the medication and specific to the residents, as appropriate f. Side effects g. Resident allergies to medications." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will	01790		

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01790	Continued From page 31 (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the	01790		

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01790	Continued From page 32 medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed comprehensive written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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:	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01790	Continued From page 33 During the entrance conference on September 23, 2024, at 10:50 a.m., clinical nurse supervisor/assisted living director (CNS/ALD)-A stated the licensee provided medication management services for all of licensee's residents. On September 24, 2024, at 2:15 p.m., CNS/ALD-A stated she had trained the staff what to do, which they would set up the medications they needed and put a note in RTasks (online electronic health record) indicating a leave of absence and staff would print the medication list for the resident to sign. When asked for the written procedures, CNS/ALD-A asked if the surveyor was looking for their policy and the surveyor explained within their policy was a requirement to have written procedures available to ULPs administering medications. CNS/ALD-A stated she did not have written procedures for unplanned times away available, just the policy. The licensee's Medication Management Plan for Residents Away from Home policy effective August 1, 2021, indicated the RN had developed written procedures/protocols for the ULPs, including special instructions regarding controlled substances, including: - the type of container(s) to be used for the medications appropriate to the facility's medication system; - how the container(s) should be labeled; - written information about the medications to be provided; - documentation requirements including date medications were provided, who received the medications, who provided the medications to the resident, the number of medications that were provided to the resident, and any other	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01790	Continued From page 34 information; - how the RN should be notified that the medications were provided and whether the RN should be notified before the medications are given to the resident or the designated representative; and -medications may be set up for the length of the anticipated absence, not to exceed seven (7) calendar days. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of two residents (R2) receiving medication management services. 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	01820		

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01820	Continued From page 35 situation has occurred only occasionally). The findings include: During the entrance conference on September 23, 2024, at 10:50 a.m., clinical nurse supervisor/assisted living director (CNS/ALD)-A stated the licensee provided medication management services to the licensee's residents. On September 24, 2024, at 9:02 a.m., unlicensed personnel (ULP)-B administered metformin and topiramate to R2. R2's diagnosis included schizophrenia (mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech and behavior), bipolar disorder (extreme mood swings), and depression. R2's Assessment by Date (nursing assessment) dated September 1, 2024, indicated R2 was forgetful and asked staff to manage his medications to help maintain mental stability. R2's electronic Medication Administration Record (eMAR) dated September 1, 2024, to September 24, 2024, indicated R2 received metformin, topiramate, atorvastatin (lowers bad cholesterol), Minipress (lowers blood pressure), risperidone (treats schizophrenia), and trazodone (treats depression). R2's record included a medication list printed off R2's electronic health record (MyChart) which lacked identification of R2 and electronic or written recorded prescriptions. On September 25, 2024, at 8:50 a.m., CNS/ALD-A stated R2 attended his medical	01820		

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01820	Continued From page 36 appointments by himself, and she requested the orders from the provider, but they never sent it. CNS/ALD-A then provided the surveyor with an "After Visit Summary" dated February 2023, but it did not include provider signatures. The licensee's Medication Orders policy effective August 1, 2021, directed the licensee will maintain a current written or electronically recorded prescription for all prescribed medications managed for the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul
6512014500

Type: Follow-Up
Date: *10/10/24*
Time: 10:09:45
Report: 1029241351

Food and Beverage Establishment Inspection Report

Location:

Alliance Homes Corporation
4946 Jackson Street Ne
Columbia Heights, MN55421
Anoka County, 02

Establishment Info:

ID #: 0039026
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632278280
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

HOT WATER: = at 189.9 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

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

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1029241351 of 10/10/24.

Certified Food Protection Manager: ABDIRIZAK M. HASSAN

Certification Number: FM101275 Expires: 10/01/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

NAFIISA DAHIR
RN LALD

Signed: Trevor McCliment

Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul
6512014500

Type: Full
Date: *09/23/24*
Time: 11:11:48
Report: 1029241327

Food and Beverage Establishment Inspection Report

Location:

Alliance Homes Corporation
4946 Jackson Street Ne
Columbia Heights, MN55421
Anoka County, 02

Establishment Info:

ID #: 0039026
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 7632278280
ID #:

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

The following orders were issued during this inspection.

3-500A Microbial Control: cooling

3-501.13E

MN Rule 4626.0380E Remove frozen fish from the reduced oxygen package prior to thawing under refrigeration or immediately after thawing if using the running water method of thawing.

VACUUM PACKED FISH THAWED WITHOUT OPENING. CLOSTRIDIUM BOTULINUM DISCUSSED WITH REP. ITEM DISCARDED BY REP.

Comply By: 09/23/24

4-300 Equipment Numbers and Capacities

4-301.12D

MN Rule 4626.0680D Mechanical warewashing equipment in lieu of a 3-compartment sink may be allowed as long as the warewashing equipment is large enough to accommodate the largest piece of equipment to be washed, rinsed and sanitized.

DISHWASHER NOT REACHING SANITIZING TEMP. OPERATOR INDICATED THEY WOULD REPAIR OR REPLACE THE DISHWASHER SHORTLY. INSTRUCTIONS PROVIDED FOR SANITIZING BY CHEMICAL AS A SHORT TERM SOLUTION UNTIL REPAIR OR REPLACEMENT.

Comply By: 09/30/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

CEILING DAMAGE ABOVE PREP COUNTER ISLAND. ITEMS MOVED OFF ISLAND. REP INSTRUCTED TO HAVE CEILING REPAIRED AND TO NOT ALLOW ANYTHING IN THE FOOD SERVICE TO BE UNDER THE DAMAGED CEILING.

Comply By: 09/30/24

Surface and Equipment Sanitizers

Food and Beverage Establishment Inspection Report

HOT WATER: = at 104 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: Yes

HOT WATER: = at 122 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: COLD HOLD/MILK
Temperature: 40 Degrees Fahrenheit - Location: UPSTAIRS REFRIGERATOR
Violation Issued: No

Process/Item: COLD HOLD/INTERNAL THERMO
Temperature: 34 Degrees Fahrenheit - Location: DOWNSTAIRS REFRIGERATOR (NO TCS)
Violation Issued: No

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

ESTABLISHMENT'S KITCHEN AREA HAS PERGO-ESQUE FLOORING, SMOOTH PAINTED WALLS AND CEILING, LAMINATE COUNTERTOPS, COMPOSITE WOOD DRAWERS AND CABINETRY WITH LAMINATE. IDENTIFIED ISSUES ADDRESSED WITH REPRESENTATIVE DURING INSPECTION.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1029241327 of 09/23/24.

Certified Food Protection Manager: ABDIRIZAK M. HASSAN

Certification Number: FM101275 Expires: 10/01/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
NAFIISA DAHIR
RN LALD

Signed: Trevor McCliment
Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Report #: 1029241327

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul

No. of RF/PHI Categories Out	0	Date	09/23/24
No. of Repeat RF/PHI Categories Out	0	Time In	11:11:48
Legal Authority MN Rules Chapter 4626		Time Out	

Alliance Homes Corporation	**Address** 4946 Jackson Street Ne	**City/State** Columbia Heights, MN	**Zip Code** 55421	**Telephone** 7632278280
License/Permit # 0039026	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 09/25/24

Inspector (Signature) Trevor McCliment