Electronically Delivered

March 26, 2024

Licensee
Alliance Group Home LLC
2205 Marshall Street Northeast
Minneapolis, MN 55418

RE: Project Number(s) SL36470015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 13, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH note violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Renee L Anderson

Renee Anderson, Supervisor
State Evaluation Team
Email: renee.anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36470	A. BUILDING: _____ B. WING _____	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIANCE GROUP HOME LLC	2205 MARSHALL STREET NE MINNEAPOLIS, MN 55418

(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: SL36470015-0 On March 11, 2024, through March 13, 2024, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 4 residents, all of whom received services under the provider's Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level pursuant to 144G.31 Subd. 1, 2 and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according	0 480		

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0 480	Continued From page 1 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 March 12, 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		
0 680 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	0 680		

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0 680	Continued From page 2 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 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 content. This had the potential to 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:	0 680		

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0 680	Continued From page 3 The licensee's Assisted Living Emergency Preparedness Manual, dated August 1, 2021, lacked the following required content: - EP policies/procedures review/updated annually; - develop policy and procedures to address: - use of volunteers, including the process/role for integration; - role of the licensee under a waiver declared by the secretary in accordance with section 1135; - develop a written communication plan and review/update annually; On March 11, 2024, at 1: 54 p.m., licensed assisted living director/owner (LALD/O)-A, stated she was not aware the EPP was missing required content and was not aware the plan needed to be reviewed annually. The licensee's 1.17 Emergency Preparedness policy, dated August 1, 2021, indicated the emergency preparedness plan would be reviewed/updated annually. The policy lacked language to include the remainder of the above elements of appendix Z. 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 (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:	0 780		

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0 780	Continued From page 4 (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 interconnected smoke alarms throughout the facility. 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:	0 780		

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0 780	Continued From page 5 On a facility tour on March 13, 2024, at 10:15 a.m., with licensed assisted living director/owner (LALD/O)-A, it was observed that smoke alarms in resident sleeping rooms number 3, and number 5, and in the upstairs hallway were not interconnected so activation of one alarm activated all alarms throughout the facility. All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit. Alarms receiving power from the building electrical system that are replaced are required to continue receiving power from the building electrical system. Additional alarms may be battery operated but are required to be interconnected with the alarms powered by the building electrical system. During the tour the smoke alarms were tested and LALD/O-A, verified the smoke alarms were not interconnected so activation of one alarm activated all alarms throughout the facility. TIME PERIOD FOR CORRECTION: Two (2) days.	0 780		
0 800 SS=D	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.	0 800		

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0 800	Continued From page 6 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 a limited number of 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 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). Findings include: On a facility tour on March 13, 2024, at 10:20 a.m., with licensed assisted living director/owner (LALD/O)-A, the surveyor made the following observations of facility hazards and disrepair: The hardware latch levers to open the storm window were removed from the storm window and the storm window was not able to be opened without special knowledge or tools in occupied resident sleeping room number 1. The hardware handles were replaced, and the storm window was operable while survey staff was still on-site. During a facility tour on March 13, 2024, at 10:30 a.m., LALD/O-A, verified the above listed observations while accompanying on the tour.	0 800		

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0 800	Continued From page 7 TIME PERIOD FOR CORRECTION: Two (2) 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. (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.	0 810		

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0 810	Continued From page 8 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 required content, make the plan readily available, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 13, 2024, at 10:45 a.m., licensed assisted living director/owner (LALD/O)-A, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee FSEP undated, failed to include the following: The number of resident sleeping rooms were not included on the evacuation floor plan. The resident room numbers are required to be included on the evacuation floor plan to be used by occupants for direction and communication in the event of evacuation for fire or similar emergency.	0 810		

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0 810	Continued From page 9 The FSEP did not identify specific fire protection actions for residents evident by failing to include written procedures for residents to take during a fire or similar emergency. The FSEP included standard resident evacuation procedures, but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The FSEP failed to include written evacuation status for each resident kept available for immediate use with the FSEP. During an interview on March 13, 2024, at 10:55 a.m., LALD/O-A, stated the resident room numbers were not included on the evacuation plan, the resident procedures required during a fire or similar emergency and resident evacuation statuses were not included in the FSEP. TRAINING Record review indicated the licensee failed to provided evacuation training to residents at least once per year as evident by not providing documentation the residents were offered training al least annually. Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year as evident by providing documentation general fire safety training was provided but not training specific to this facility FSEP. During an interview on March 13, 2024, at 11:00 a.m., LALD/O-A stated the training documentation for residents was not available and the	0 810		

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0 810	Continued From page 10 documentation available for training of employees was not specific to the facility FSEP. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by providing documentation fire evacuation drills were performed 2 times in 2023, on January 15, 2023, and April 16, 2023. During an interview on March 13, 2024, at 11:10 a.m., LALD/O-A stated documentation was not available in the required sequence of twice per shift per year and every other month. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
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 waiving the facility's liability for health, safety, or personal	0 970		

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0 970	Continued From page 11 property of a resident. This had the potential to affect all the licensee's 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 the residents). The findings include: On March 11, 2024, at 1:00 p.m., the licensed assisted living director/owner (LALD/O)-A provided the surveyor with a binder filled with blank forms, including the forms for the licensee's Assisted Living Contract. The blank Assisted Living Contract included the following section, indicating a waiver of liability: Indemnification: The licensee, "shall not be liable for any damage or injury to the resident, or any other person, 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 from any claims or damages unless caused solely by negligence of [licensee]. It is recommended that renter's insurance be purchased at the resident's expense. Nothing contained herein is intended to create a waiver of facility liability for the health and safety or personal property of a resident." On March 12, 2024, at 1:30 p.m., LALD/O-A stated she was aware the above referenced language was prohibited, and thought she had an addendum for the contract that had been signed by the residents. LALD/O-A further stated she	0 970		

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0 970	Continued From page 12 would look for the signed addendums. On March 13, 2024, at 2:50 p.m., LALD/O-A stated she was unable to find the signed addendums. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by:	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36470	A. BUILDING: _____ B. WING _____	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIANCE GROUP HOME LLC	2205 MARSHALL STREET NE MINNEAPOLIS, MN 55418

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01640	Continued From page 13 Based on observation, interview, and record review, the licensee failed to ensure a current written service plan was revised and included a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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's was admitted on May 17, 2021, and had diagnoses to included traumatic brain injury and dementia. On March 12, 2024, at 8:38 a.m., the surveyor observed unlicensed personnel (ULP)-C assist R2 with medication administration. R2's signed service plan dated August 15, 2022, indicated R2 received services to include assistance with bathing twice a day, three times per week and assistance with dressing daily. R2's unsigned service plan, printed March 12, 2024, indicated R2's bathing assistance was decreased to once a day, three times per week and dressing assistance increased to twice per day. Nail care was also added to the service plan to be done twice per day. R2's service plan lacked authentication of the revisions.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36470	A. BUILDING: _____ B. WING _____	03/13/2024

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01640	Continued From page 14 On March 12, 2024, at 11:27 a.m., clinical nurse supervisor (CNS)-B stated, R2's last signed service plan was August 15, 2022, and he was aware there were revisions made to R2's services provided. CNS-B stated the updated service plan had not been authenticated by the facility and the resident or resident's representative. The licensee's 1.7 Service Plan policy dated August 1, 2021, included, "the initial service plan and any revisions are signed by a representative from [Licensee] and the resident or resident's representative, indicating agreement with the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescriptions were renewed at least every 12 months for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an	01830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36470	A. BUILDING: _____ B. WING _____	03/13/2024

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01830	Continued From page 15 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's was admitted on May 17, 2021, with services to include assistance with medication management, dressing and bathing. On March 12, 2024, at 8:38 a.m., unlicensed personnel (ULP)-C was observed to assist R2 with medication administration. R2's medication administration record (MAR) for February 1, 2024, through March 13, 2024, indicated R2 was administered the following medications daily: -certa-vite/lutein (vitamin supplement) 1 tablet; -doxazosin (for hypertension), 8 milligram (mg); -fluoxetine (for depression), 40 mg; -quetiapine (for bipolar disorder), 75 mg; and -risperidone (for depression), 2 mg. R2's record included prescriber orders signed November 29, 2022, for the above medications, but lacked updated orders signed within the last 12 months. On March 12, 2024, at 2:00 p.m., clinical nurse supervisor (CNS)-A stated the orders in R2's record were the most current signed orders. CNS-A further stated it was the registered nurse's responsibility to get signed orders from the provider at least every 12 months and R2's orders were "missed." The licensee's 3.7 Medication Orders policy, dated August 1, 2021, indicated medication	01830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36470	A. BUILDING: _____ B. WING _____	03/13/2024

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01830	Continued From page 16 orders would be renewed by the provider at least every 12 months, and kept in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of two 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) 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:	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01970	Continued From page 17 R2's was admitted on May 17, 2021, with services to include assistance with medication management and oxygen saturation level checks. R2's signed service plan dated August 15, 2022, indicated R2 received services to include recording oxygen saturation two times per day, daily. On March 12, 2024, at 8:38 a.m., unlicensed personnel (ULP)-C was observed to check R2's oxygen saturation level with a pulse oximeter (devise used to measure blood oxygen levels and pulse). R2's record included prescriber orders, signed November 29, 2022, which indicated to monitor and record oxygen saturation two times per day, daily. R2's record lacked updated orders signed within the last 12 months. On March 12, 2024, at 2:00 p.m., clinical nurse supervisor (CNS)-A stated the orders in R2's record were the most current signed orders. CNS-A stated it was the registered nurse's responsibility to get signed orders from the provider at least every 12 months and R2's orders were "missed." The licensee's 2.13 Treatment and Therapy Management policy, dated August 1, 2021, indicated the registered nurse (RN) would obtain orders and prescriptions for all treatments and therapies. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Follow-Up
Date: *03/12/24*
Time: 16:02:35
Report: 1039241067

Food and Beverage Establishment Inspection Report

Location:
Alliance Group Home Llc
2205 Marshall Street Ne
Minneapolis, MN55418
Hennepin County, 27

Establishment Info:
ID #: 0039158
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6122810077
ID #:

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

The following orders previously issued on 03/11/24 have NOT been corrected.

2-100 Supervision

2-102.12AMN

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

STAFF MEMBER COMPLETED AN APPROVED FOOD SAFETY COURSE IN OCTOBER, 2023. MUST REGISTER WITH MN DEPT OF HEALTH TO OBTAIN CFPM CERTIFICATE. CFPM GUIDANCE DOCUMENT SENT WITH REPORT.

Issued on: 03/11/24 *Comply By: 03/29/24*

No NEW orders were issued during this inspection.

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

Follow-up based on photographs emailed by person-in-charge. Egg stacking and date marking violations removed from report.

Type: Follow-Up
Date: *03/12/24*
Time: 16:02:35
Report: 1039241067
Alliance Group Home Llc

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1039241067 of 03/12/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Rukia Sharif-Isaack
person-in-charge

Signed:_____
Aron Goodner
Public Health Sanitarian I
Freeman Building
aron.goodner@state.mn.us