



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 17, 2026

Licensee

Alliance Home Health Care LLC
803 Weeks Avenue Southeast
Minneapolis, MN 55414

RE: Project Number(s) SL35842016

Dear Licensee:

On November 11, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on August 21, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the August 21, 2025 survey.

The Department of Health 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.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last , completed on August 21, 2025, found not corrected at the time of the November 11, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b-F) - \$500.00

The details of the violations noted at the time of this follow-up survey completed on November 11, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to

correct the violation first as follows:

Level 1: no fines or enforcement;

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

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

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

Level 5: a fine of \$5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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.

We urge you to review these orders carefully. If you have questions, please contact Stephanie Jones de Palma at 651-201-4320.

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

Sincerely,

A handwritten signature in black ink, reading "Stephanie Jones de Palma". The signature is written in a cursive style with a large, sweeping initial 'S'.

Stephanie Jones de Palma, Supervisor

State Evaluation Team

Email: stephanie.jones.de.palma@state.mn.us

Telephone: 651-201-4320 Fax: 1-866-890-9290

KKM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38714	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/11/2025
NAME OF PROVIDER OR SUPPLIER ALLIANCE HOME HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 803 WEEKS AVENUE SOUTHEAST MINNEAPOLIS, MN 55414		
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{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL38714016-1 On November 10, 2025, through February 26, 2026, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on August 21, 2025. At the time of the survey, there were 4 residents; 4 receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were issued and/or reissued.	{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.		
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	{0 470}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 470}	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 470}			
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.	{0 480}			

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{0 480}	Continued From page 2 (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant	{0 480}			

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STATE FORM

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{0 680}	Continued From page 4 (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 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: Not reviewed during this survey.	{0 680}			
{0 700} SS=D	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information.	{0 700}			

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{0 780}	Continued From page 6 Not reviewed during this survey.	{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: Not reviewed during this survey.	{0 800}			
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans	{0 810}			

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{0 810}	Continued From page 7 upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content. 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 the potential to affect a large portion or all of the residents). The findings include: On November 10, 2025, at 10:26 a.m. the surveyor initiated a desk follow-up on orders	{0 810}			

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{0 810}	Continued From page 8 issued pursuant to a survey completed on August 21, 2025. The surveyor emailed the facility and requested updated fire safety and evacuation policy (FSEP) that included staff and resident actions, unique or unusual needs for resident movement during evacuation or similar emergencies, and staff and resident training on the facilities FSEP. On November 11, 2025, at 1:57 p.m. the facility provided the requested documentation in an email. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Safety", dated October 7, 2022, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.	{0 810}			
{01320} SS=D	144G.60 Subd. 4 (a) Unlicensed personnel (a) Unlicensed personnel providing assisted living services must have: (1) successfully completed a training and competency evaluation appropriate to the services provided by the facility and the topics listed in section 144G.61, subdivision 2,	{01320}			

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{01320}	Continued From page 9 paragraph (a); or (2) demonstrated competency by satisfactorily completing a written or oral test on the tasks the unlicensed personnel will perform and on the topics listed in section 144G.61, subdivision 2, paragraph (a); and successfully demonstrated competency on topics in section 144G.61, subdivision 2, paragraph (a), clauses (5), (7), and (8), by a practical skills test. Unlicensed personnel who only provide assisted living services listed in section 144G.08, subdivision 9, clauses (1) to (5), shall not perform delegated nursing or therapy tasks. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01320}			
{01330} SS=D	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner.	{01330}			

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{01330}	Continued From page 10	{01330}			
{01460} SS=D	This MN Requirement is not met as evidenced by: Not reviewed during this survey. 144G.63 Subdivision 1 Orientation of staff and supervisors (a) All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility, except as provided in paragraph (b). (b) A staff person is not required to repeat the orientation required under subdivision 2 if the staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of the first facility, or to another facility managed by the same entity managing the first facility. The facility to which the staff person transfers must document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with supplemental orientation specific to the facility and document that the supplemental orientation was provided. The supplemental orientation must include the types of assisted living services the staff person will be providing, the facility's category of licensure, and the facility's emergency procedures. A staff person cannot transfer to an assisted living facility with dementia care without	{01460}			

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{01460}	Continued From page 11 satisfying the additional training requirements under section 144G.83. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01460}			
{01530} SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation	{01530}			

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{01530}	Continued From page 12 and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01530}			
{01620} SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must	{01620}			

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{01620}	Continued From page 13 be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01620}			
{01730} SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse,	{01730}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38714	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/11/2025
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{01730}	Continued From page 14 advanced practice registered nurse, or qualified staff delegated the task by a registered nurse 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 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	{01730}			

Minnesota Department of Health

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{01730}	Continued From page 15 medication management. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01730}			
{01750} SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01750}			
{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: Not reviewed during this survey.	{01820}			

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{02320}	Continued From page 16	{02320}			
{02320} SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{02320}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 6, 2025

Licensee

Alliance Home Health Care LLC
803 Weeks Avenue Southeast
Minneapolis, MN 55414

RE: Project Number(s) SL38714016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 21, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

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

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

Level 5: a fine of \$5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - \$500.00

0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - \$1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,



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

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38714	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/21/2025
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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: SL38714016-0 On August 18, 2025, through August 21, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were four residents; four receiving services under the Assisted Living Facility license.		0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for		0 470		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. 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	0 470			

Minnesota Department of Health

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0 470	Continued From page 2 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 August 18, 2025, at 9:45 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated one unlicensed personnel (ULP) worked each shift and the shift schedule was 8:00 a.m. until 4:00 p.m., 4:00 p.m. until 11:00 p.m., and 11:00 p.m. until 8:00 a.m. and the CNS/LALD was at the facility as needed. On August 18, 2025, at 2:32 p.m., the surveyor requested to see the facility staffing plan. CNS/LALD-C stated the staffing plan was the staff schedule. CNS/LALD-C presented the staff schedule that listed staff names with their assigned shift times. The document lacked an evaluation by a registered nurse (RN) and a date. CNS/LALD-C stated they were unaware of the staffing plan requirements. The licensee's Staffing policy dated October 7, 2022, indicated the clinical nurse supervisor would develop and implement a staffing plan that provides an adequate number of quality staff to meet the residents needs 24-hours a day, seven days a week. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			

Minnesota Department of Health

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0 480	Continued From page 3	0 480			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink;	0 480			

Minnesota Department of Health

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0 480	Continued From page 4 (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 19, 2025, for the specific Minnesota Food Code violations. The Inspection	0 480			

Minnesota Department of Health

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0 480	Continued From page 5 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			
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control. This practice had the potential to affect the licensee's 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 an isolated scope (when one or a limited number of residents are affected or one or	0 510			

Minnesota Department of Health

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0 510	Continued From page 6 a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On August 19, 2025, at 8:37 a.m., the surveyor observed owner/agent (O/A)-B prepare to administer insulin to R3. O/A-B performed hand hygiene and put gloves on. O/A-B opened the insulin injection pen (a device that is used to inject insulin), primed the insulin to the required dose and uncapped the needle. O/A-B cleaned the abdominal area with an alcohol pad, picked up the pen and injected the insulin into R3. The surveyor observed O/A-B cap the needle and remove it from the insulin injection pen. O/A-B walked to the sharps container. O/A-B attempted to dispose of the needle into a sharps container but was unable to open the lid. CNS/LALD-C instructed O/A-B to cover the capped needle with the method of rolling their glove off, incapsulating the capped needle. CNS/LALD-C placed a glove onto their left hand and O/A-B placed the glove containing the capped needle into CNS/LALD-C's left hand. CNS/LALD-C opened the sharps container with their right hand and placed the glove containing the capped needle into the sharps container. CNS/LALD-C removed the single glove and did not perform hand hygiene after disposing of the glove. On August 19, 2025, at 8:50 a.m. CNS/LALD-C stated staff were trained to perform hand hygiene. CNS/LALD-C stated the reason they did not perform hand hygiene was they did not come into contact with bodily fluids and was unaware of the current Center for Disease Control recommendations for hand hygiene. The licensee's Infection Control policy dated	0 510			

Minnesota Department of Health

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0 510	Continued From page 7 October 7, 2022, indicated licensee would follow infection control practices as recommended by the CDC. The CDC's Clinical Safety: Hand Hygiene for Healthcare Works dated February 27, 2024, recommended to perform hand hygiene after contact with blood, body fluids or contaminated surfaces. The CDC recommended performing hand hygiene after glove removal. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
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	0 680			

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0 680	Continued From page 8 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 maintain a written emergency preparedness (EP) plan with all the required content as defined in Appendix Z. 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: The licensee's undated emergency disaster preparedness plan, lacked evidence of the following required content: - program patient population: identify at risk population needs like maintaining independence, communication, transportation, supervision and medical care; -procedures for tracking of staff and patients; -policies and procedures including evacuation; -policies and procedures for medical documents; -policies and procedures for volunteers; -arrangement with other facilities; -development of communication plan; -names and contact information of names and	0 680			

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0 680	Continued From page 9 contact information for entities providing services under agreement, residents physicians, and volunteers; -primary/alternate means for communication; -methods for sharing information; -sharing information on occupancy/needs, and; -long-term care family notifications. On August 20, 2025, at 12:29 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated they purchased the EP plan from a consultant company and believed it contained all the required information. CNS/LALD-C stated they were unaware the EP plan was not compliant. The licensee's Emergency Preparedness policy dated October 7, 2022, indicated licensee would 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			
0 700 SS=D	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information.	0 700			

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0 700	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of five resident's (R4) personal health and medical information was kept private. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4 was admitted to the assisted living facility on January 3, 2024, and began receiving assisted living services. On August 18, 2025, at 10:52 a.m., in the lower level of the two-story home, located in the dining area on the wall was a document titled Genoa healthcare. The surveyor observed residents in and around the dining area. The document contained the following information, "[R4] lisinopril 40 mg (milligram), citalopram 40 mg, vitamin D3 50 mcg (micrograms), ferrous sulf, 325 mg, atorvastatin 10 mg, xarel 10 mg, gabapentin 100 mg, gabapentin 300 mg." On August 18, 2025, at 2:32 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated all health information was required to be kept confidential, and that information should not be displayed.	0 700			

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0 700	Continued From page 11 The licensee's Privacy of Protected Health Information policy dated October 7, 2022, indicated licensee would protect the privacy of its resident's personal health information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700			
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: (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;	0 780			

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0 780	Continued From page 12 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This deficient condition had 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 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 August 19, 2025, the surveyor toured the facility with clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C. The surveyor asked CNS/LALD-C to initiate a test of the interconnected smoke alarms throughout the facility. Upon testing the smoke alarms, it was discovered that the facility is equipped with 4 different smoke alarm brands/systems in all required locations. The common hallways are equipped with a hard-wired smoke alarm that is required by Minnesota State Fire Code to remain.	0 780			

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0 780	Continued From page 13 There were single station smoke alarms that were not interconnected, an X-sense brand smoke alarm system that was no longer interconnected, and Performax brand smoke alarms that were interconnected with each other only. Where hard wired smoke alarms are present, they must be maintained as hard wired. Any newly introduced smoke alarms may be battery operated. 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. TIME PERIOD FOR CORRECTION: Two (2) days	0 780			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings,	0 800			

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0 800	Continued From page 14 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. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 19, 2025, the surveyor toured the facility with clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C. The following was observed. In resident room 1 there was vegetation on the outside of the casement style egress window that prevented the window from opening enough to meet the required egress measurements. CNS/LALD-C stated that they would need to remove the vegetation so that the window could open fully. Resident room 2 was provided with bifold closet doors. The hinges in the middle of the bifold doors were ton secured to both doors. CNS/LALD-C stated that they were not aware of the closet doors being damaged and said that they will need to contact the landlord.	0 800			

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0 800	Continued From page 15 In resident room 3 the bottom of the casement style egress window sash was not secured to the window frame. CNS/LALD-C stated that they were not aware of the window needing repair and that they would need to contact the landlord. In the first-floor bathroom there was discoloration around the ceiling fan that is consistent with a roof leak. CNS/LALD-C stated that the roof had been replaced, and did not answer the surveyor when asked if there was an active roof leak. CNS/LALD-C stated that they would have to contact their landlord to have the ceiling repaired. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=I	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.	0 810			

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0 810	Continued From page 16 (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) 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:	0 810			

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0 810	Continued From page 17 On August 19, 2025, clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C 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's FSEP, titled "Fire Safety", dated October 7, 2022, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of 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 plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. CNS/LALD-C stated that residents are offered training, but	0 810			

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0 810	Continued From page 18 lacked documentation showing any training was offered or training was scheduled for a future date for residents on the FSEP. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. CNS/LALD-C stated that staff are trained annually in EduCare and not on the facilities FSEP. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
01320 SS=D	144G.60 Subd. 4 (a) Unlicensed personnel (a) Unlicensed personnel providing assisted living services must have: (1) successfully completed a training and competency evaluation appropriate to the services provided by the facility and the topics listed in section 144G.61, subdivision 2, paragraph (a); or (2) demonstrated competency by satisfactorily completing a written or oral test on the tasks the unlicensed personnel will perform and on the topics listed in section 144G.61, subdivision 2, paragraph (a); and successfully demonstrated competency on topics in section 144G.61, subdivision 2, paragraph (a), clauses (5), (7), and (8), by a practical skills test. Unlicensed personnel who only provide assisted living services listed in section 144G.08, subdivision 9, clauses (1) to (5), shall not perform delegated nursing or therapy tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency	01320			

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01320	Continued From page 19 evaluations were completed for all required skill areas prior to providing services, for one of three (unlicensed personnel (ULP)-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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-A was hired April 25, 2024, to provide direct care services. ULP-A's employee file contained a document titled Manage Users - Courses Assigned [ULP-A]. The document indicated the following courses had been assigned to ULP-A but not had been completed: - activities for older adults; - aging process; - assisted living bill of rights; - client mobility - exercise; - client mobility - exercise and ambulation; - client mobility - lifting and safe transfers; - client mobility - positioning; - client mobility - range of motion; - customer service; - customer service - doing it right; - customer service - the moving target; - dementia - activities - bathing; - dementia - activities - chores, working and volunteering; - dementia - activities - dressing and grooming; - dementia communication overview;	01320			

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01320	Continued From page 20 - dementia 3 activities of daily living; - dining, nutritional and food safety; - documenting, observing and reporting; - emergency preparedness - human hazards; - emergency preparedness - overview; - emergency preparedness - overview Spanish; - emergency preparedness - site and natural hazards; - emergency preparedness - sit and natural hazards Spanish; - fall prevention; - housekeeping, laundry, and bedmaking; - maintenance; - medication administration; - mental illness 1 -overview and depression; - mental illness 2 - bipolar, anxiety, psychosis and trauma induced disorders; - mental illness 3 - personality disorders, substance abuse and de-escalation; - occupational safety and health administration (OSHA) and infection control; - OSHA and infection control; - personal cares; - professional boundaries and; - vital signs. ULP-A's employee record lacked the following required content training for: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the assisted living provider; - basic infection control, including blood-borne pathogens; - maintenance of a clean and safe environment; - appropriate and safe techniques in personal hygiene and grooming, including: hair care and bathing, care of teeth, gums, and oral prosthetic devices, care and use of hearing aids, and	01320			

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01320	Continued From page 21 dressing and assisting with toileting; - training on the prevention of falls for providers working with the elderly or individuals at risk of falls; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the - resident's preferences, cultural background, and family; - awareness of confidentiality and privacy; - understanding appropriate boundaries between staff and residents and the resident's family; - procedures to utilize in handling various emergency situations; and - awareness of commonly used health technology equipment and assistive devices. On August 20, 2025, at 12:48 p.m. clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated they were responsible for assigning the Educare (a software program used for training) to staff. CNS/LALD-C stated they were unsure why the training was not completed. The licensee's Staff Orientation and Education policy dated October 7, 2022, indicated staff would receive orientation training on the above missing topics. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01320			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38714	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER ALLIANCE HOME HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 803 WEEKS AVENUE SOUTHEAST MINNEAPOLIS, MN 55414		
(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
01330	Continued From page 22	01330			
01330 SS=D	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas prior to providing services, for one of three (unlicensed personnel (ULP)-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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01330			

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01330	Continued From page 23 The findings include: ULP-A was hired April 25, 2024, to provide direct care services. ULP-A's employee file contained a document titled Manage Users - Courses Assigned [ULP-A]. The document indicated the following courses had been assigned to ULP-A but not had been completed: - activities for older adults; - aging process; - assisted living bill of rights; - client mobility - exercise; - client mobility - exercise and ambulation; - client mobility - lifting and safe transfers; - client mobility - positioning; - client mobility - range of motion; - customer service; - customer service - doing it right; - customer service - the moving target; - dementia - activities - bathing; - dementia - activities - chores, working and volunteering; - dementia - activities - dressing and grooming; - dementia communication overview; - dementia 3 activities of daily living; - dining, nutritional and food safety; - documenting, observing and reporting; - emergency preparedness - human hazards; - emergency preparedness - overview; - emergency preparedness - overview Spanish; - emergency preparedness - site and natural hazards; - emergency preparedness - sit and natural hazards Spanish; - fall prevention; - housekeeping, laundry, and bedmaking; - maintenance;	01330			

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01330	Continued From page 24 - medication administration; - mental illness 1 -overview and depression; - mental illness 2 - bipolar, anxiety, psychosis and trauma induced disorders; - mental illness 3 - personality disorders, substance abuse and de-escalation; - occupational safety and health administration (OSHA) and infection control; - OSHA and infection control; - personal cares; - professional boundaries and; - vital signs. ULP-A's employee record lacked the following required content training for: - observation, reporting, and documenting of resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must - be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning, and; - administering medications or treatments as required. On August 20, 2025, at 12:48 p.m. clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated they were responsible for assigning the Educare (a software program used for training) to staff. CNS/LALD-C stated they were unsure why the training was not completed. The licensee's Staff Orientation and Education policy dated October 7, 2022, indicated staff would receive orientation training on the above	01330			

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01330	Continued From page 25 missing topics. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01330			
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors (a) All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility, except as provided in paragraph (b). (b) A staff person is not required to repeat the orientation required under subdivision 2 if the staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of the first facility, or to another facility managed by the same entity managing the first facility. The facility to which the staff person transfers must document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with supplemental orientation specific to the facility and document that the supplemental orientation was provided. The supplemental orientation must include the types of assisted living services the staff person will be providing, the facility's category of licensure, and the facility's emergency	01460			

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01460	Continued From page 26 procedures. A staff person cannot transfer to an assisted living facility with dementia care without satisfying the additional training requirements under section 144G.83. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required training content for one of three employees (unlicensed personnel (ULP)-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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-A was hired April 25, 2024, to provide direct care services. ULP-A's employee file contained a document titled Manage Users - Courses Assigned [ULP-A]. The document indicated the following courses had been assigned to ULP-A but not had been completed: - activities for older adults; - aging process; - assisted living bill of rights; - client mobility - exercise; - client mobility - exercise and ambulation; - client mobility - lifting and safe transfers; - client mobility - positioning;	01460			

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01460	Continued From page 27 - client mobility - range of motion; - customer service; - customer service - doing it right; - customer service - the moving target; - dementia - activities - bathing; - dementia - activities - chores, working and volunteering; - dementia - activities - dressing and grooming; - dementia communication overview; - dementia 3 activities of daily living; - dining, nutritional and food safety; - documenting, observing and reporting; - emergency preparedness - human hazards; - emergency preparedness - overview; - emergency preparedness - overview Spanish; - emergency preparedness - site and natural hazards; - emergency preparedness - sit and natural hazards Spanish; - fall prevention; - housekeeping, laundry, and bedmaking; - maintenance; - medication administration; - mental illness 1 -overview and depression; - mental illness 2 - bipolar, anxiety, psychosis and trauma induced disorders; - mental illness 3 - personality disorders, substance abuse and de-escalation; - occupational safety and health administration (OSHA) and infection control; - OSHA and infection control; - personal cares; - professional boundaries and; - vital signs. ULP-A's employee record lacked the following required content training for: - overview of Assisted Living statutes; - review of provider's policies and procedures; - handling emergencies and using emergency	01460			

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01460	Continued From page 28 services; - reporting maltreatment of vulnerable adults or minors; - assisted living bill of rights; - handing of resident complaints, reporting of complaints, where to report; - consumer advocacy services; - review of types of Assisted Living services the employee will provide and provider's scope of license, and; - principles of person-centered planning/service delivery. On August 20, 2025, at 12:48 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated they were responsible for assigning the Educare (a software program used for training) to staff. CNS/LALD-C stated they were unsure why the training was not completed. The licensee's Staff Orientation and Education policy dated October 7, 2022, indicated staff would receive orientation training on the above missing topics. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460			
01530 SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1)	01530			

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01530	Continued From page 29 to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct-care staff completed at least eight hours of initial training on	01530			

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01530	Continued From page 30 topics specified under paragraph (b) within 160 working hours of the employment start date for one of three employees (unlicensed personnel (ULP)-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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-A was hired on April 25, 2024, and began to provide direct care and services to residents. ULP-A's employee file lacked the following: - required eight hours of dementia training, and; - two hours of mental illness and de-escalation training. On August 20, 2025, at 12:29 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated they did not keep a copy of previously worked shifts for staff. CNS/LALD-C stated ULP-A worked 30 hours per month. CNS/LALD-C stated they were responsible for the training of staff. CNS/LALD-C stated they were aware of the required training and was unsure why it was not completed. The licensee's Dementia Education policy dated October 7, 2022, indicated employees who provide direct care services would complete at least eight hours of dementia care training within 160 hours of employment.	01530			

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01530	Continued From page 31 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days		01530		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part		01620		

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01620	Continued From page 32 of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted a reassessment, not to exceed 90 calendar days for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the facility on February 5, 2025, and began receiving assisted living	01620			

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01620	Continued From page 33 services. R1's Service (Waiver) - Addendum to Contract dated August 6, 2025, indicated R1 received assistance with medication administration, bathing, bedmaking, deep room cleaning, dressing, grooming, housekeeping, laundry, linen change, behavioral management, meals, and shopping. R1's diagnoses included schizophrenia (a mental health condition that causes the person to experience hallucinations, delusions, disorganized thinking and negative symptoms), bipolar disorder (a mental health condition that causes a person to experience mood swings, energy fluctuations and disruptions in daily functioning), depression, generalized anxiety disorder, post-traumatic stress disorder. R1's record included a Nurse Assessment dated April 8, 2025; the next 90-day assessment should have been completed by July 7, 2025; however, the next assessment was completed August 18, 2025. The assessment was 42 days late. On August 18, 2025, at 9:45 a.m., during the entrance conference, clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated ongoing assessments should be completed every 90 days or with a change of condition. On August 21, 2025, at 10:58 a.m., via telephone, CNS/LALD-C stated they had completed an assessment in June for R1 and would email that to the surveyor after the phone conversation. On August 21, 2025, the surveyor did not receive the June assessment for R1.	01620			

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01620	Continued From page 34 The licensee's Assessment and Reassessment policy dated October 7, 2022, indicated a registered nurse (RN) would conduct an assessment every 90 days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse 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 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;	01730			

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NAME OF PROVIDER OR SUPPLIER ALLIANCE HOME HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 803 WEEKS AVENUE SOUTHEAST MINNEAPOLIS, MN 55414		
(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
01730	Continued From page 35 (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse reconciled medication orders for one of three residents reviewed (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the facility on February 5, 2025, and began receiving assisted living	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38714	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER ALLIANCE HOME HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 803 WEEKS AVENUE SOUTHEAST MINNEAPOLIS, MN 55414		
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01730	Continued From page 36 services. R1's Service (Waiver) - Addendum to Contract dated August 6, 2025, indicated R1 received assistance with medication administration. R1's medication administration record (MAR) dated August 1, 2025, through August 31, 2025, indicated R1 received the following medications: acetaminophen 500 milligram (mg) 2 tablets three times daily, amlodipine 5 mg 1 tablet once daily, gabapentin 300 mg 1 capsule three times daily, haloperidol 5 mg 1 tablet once daily, Invega Sustenna 234 micro gram (mcg) injection into muscle 1 each month, methocarbamol 500 mg 1 and one-half tablet each day, tamsulosin 0.4 capsule once daily, hydromorphone 4 mg 1 - 1.5 tablets every four hours, hydroxyzine 25 mg 1 to 2 capsules every six hours as needed, and oxycodone 5 mg give 1 to 2 tablets by mouth every four hours as needed. R1's record contained signed orders with varying dates from a medical prescriber for the following medications: acetaminophen 500 milligram (mg) 2 tablets three times daily, amlodipine 5 mg 1 tablet once daily, gabapentin 300 mg 1 capsule three times daily, haloperidol 5 mg 1 tablet once daily, Invega Sustenna 234 micro gram (mcg) injection into muscle 1 each month, methocarbamol 500 mg 1 and one-half tablet each day, tamsulosin 0.4 capsule once daily, hydromorphone 4 mg 1 - 1.5 tablets every four hours, hydroxyzine 25 mg 1 to 2 capsules every six hours as needed, oxycodone 5 mg give 1 to 2 tablets by mouth every four hours as needed, Senoxon-S 8.6-50 mg 1 tablet by mouth as needed, sildenafil 100 mg 1 tablet once daily as needed, cyclobenzaprine 20 mg 1 tablet as needed and, polyethylene glycol 3350 17 gm	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38714	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/21/2025
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01730	Continued From page 37 once daily as needed. R1's record contained signed prescription orders for the following medications, however, they were not listed on the MAR: Senoxon-S 8.6-50 mg 1 tablet by mouth as needed, sildenafil 100 mg 1 tablet once daily as needed, cyclobenzaprine 20 mg 1 tablet as needed, and polyethylene glycol 3350 17 gm once daily as needed. On August 20, 2025, at 12:33 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated they were responsible for the medications for residents. CNS/LALD-C stated when a medication was prescribed it would appear in the electronic medical record (EMAR). CNS/LALD-C stated they were unsure why some of the prescription orders did not match the MAR. The licensee's Medication Order policy dated October 7, 2022, indicated licensee would maintain a current written or electronic recorded prescription for all prescribed medications for the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated	01750			

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01750	Continued From page 38 the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified in writing, specific instructions for medication administration for one of three residents reviewed (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the facility on February 5, 2025, and began receiving assisted living services. R1's Service (Waiver) - Addendum to Contract dated August 6, 2025, indicated R1 received assistance with medication administration. R1's medication administration record (MAR) August 1, 2025, through August 31, 2025, indicated R1 received the following medications: acetaminophen 500 milligram (mg) 2 tablets three times daily, amlodipine 5 mg 1 tablet once daily,	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38714	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/21/2025
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01750	Continued From page 39 gabapentin 300 mg 1 capsule three times daily, haloperidol 5 mg 1 tablet once daily, Invega Sustenna 234 micro gram (mcg) injection into muscle 1 each month, methocarbamol 500 mg 1 and one-half tablet each day, tamsulosin 0.4 capsule once daily, hydromorphone 4 mg 1 - 1.5 tablets every four hours, hydroxyzine 25 mg 1 to 2 capsules every six hours as needed, and oxycodone 5 mg give 1 to 2 tablets by mouth every four hours as needed. R1's record contained signed orders with varying dates from a medical prescriber for the following medications: acetaminophen 500 milligram (mg) 2 tablets three times daily, amlodipine 5 mg 1 tablet once daily, gabapentin 300 mg 1 capsule three times daily, haloperidol 5 mg 1 tablet once daily, Invega Sustenna 234 micro gram (mcg) injection into muscle 1 each month, methocarbamol 500 mg 1 and one-half tablet each day, tamsulosin 0.4 capsule once daily, hydromorphone 4 mg 1 - 1.5 tablets every four hours, hydroxyzine 25 mg 1 to 2 capsules every six hours as needed, oxycodone 5 mg give 1 to 2 tablets by mouth every four hours as needed, Senoxon-S 8.6-50 mg 1 tablet by mouth as needed, sildenafil 100 mg 1 tablet once daily as needed, cyclobenzaprine 20 mg 1 tablet as needed and, polyethylene glycol 3350 17 gm once daily as needed. The following medication did not have parameters for staff to determine whether to give 1 or 2 capsules: hydroxyzine 25 mg 1 to 2 capsules every six hours as needed. On August 20, 2025, at 8:45 a.m., clinical nurse supervisor (CNS)-C stated they trained staff to follow the requests of residents to determine how many capsules to administer. CNS-C stated they	01750			

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01750	Continued From page 40 were unaware they were required to place parameters or guidance for medication for staff to follow. The licensee's Medication Administration policy dated October 7, 2022, indicated the registered nurse (RN) would prepare written instructions for staff to administer medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
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, licensee failed to maintain current signed prescription orders for all medications the licensee was managing for one of three 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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01820			

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01820	Continued From page 41 The findings include: R2 was admitted to the facility on January 26, 2023, and began receiving assisted living services. R2's Service Plan (Waiver) - Addendum to Contract dated January 26, 2023, indicated R2 received assistance with medication administration. R2's MAR dated August 1, 2025, through August 18, 2025, indicated R2 received the following medications: amlodipine 10 mg 1 tablet once daily, aspirin 81 mg 1 tablet once daily, lacosamide 100 mg 1 tablet twice daily, levetiracetam 1000mg 1 tablet twice daily, naltrexone 50 mg 1 tablet once daily, omeprazole 20 mg 1 capsule once daily, one-daily multivitamin 1 tablet once daily, sertraline 100 mg 1 tablet once daily, vitamin B-1 100 mg 1 tablet once daily, vitamin D3 5000 units (u) 1 capsule once daily, ammonium lactate 12 percent (%) cream apply 1 gram to bottom three Monday, Wednesday, Friday, atorvastatin 80 mg 1 tablet once daily, mirtazapine 15 1 tablet once daily, risperidone 2 mg 1- and one-half tablets, naloxone hydrochloride 1 spray as needed, Refresh eye drops install two drops in each eye as needed. R2's record contained signed orders with varying dates from a medical prescriber for the following medications: amlodipine 10 mg 1 tablet once daily, aspirin 81 mg 1 tablet once daily, lacosamide 100 mg 1 tablet twice daily, levetiracetam 1000mg 1 tablet twice daily, naltrexone 50 mg 1 tablet once daily, omeprazole 20 mg 1 capsule once daily, one-daily	01820			

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01820	Continued From page 42 multivitamin 1 tablet once daily, sertraline 100 mg 1 tablet once daily, vitamin B-1 100 mg 1 tablet once daily, vitamin D3 5000 units (u) 1 capsule once daily, ammonium lactate 12 percent (%) cream apply 1 gram to bottom three Monday, Wednesday, Friday, atorvastatin 80 mg 1 tablet once daily, mirtazapine 15 1 tablet once daily, risperidone 2 mg 1- and one-half tablets, naloxone hydrochloride 1 spray as needed Refresh eye drops install two drops in each eye as needed, and folic acid 1 mg 1 tablet once daily, The following medications were listed on the MAR but there were no signed prescription orders: naloxone hydrochloride 1 spray as needed, and Refresh eye drops instill two drops in each eye as needed. On August 20, 2025, at 12:33 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated they were responsible for the medications for residents. CNS/LALD-C stated when a medication was prescribed it would appear in the electronic medical record (EMAR). CNS/LALD-C they would keep a hard copy of the prescription on file. CNS/LALD-C stated they were unsure why there was missing prescriptions. The licensee's Medication Order policy dated October 7, 2022, indicated licensee would maintain a current written or electronic recorded prescription for all prescribed medications for the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			

Minnesota Department of Health

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02320	Continued From page 43	02320			
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff followed appropriate medication administration procedures for one of two staff (unlicensed personnel (ULP)-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, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's Service (Waiver) - Addendum to Contract dated August 6, 2025, indicated R1 received assistance with medication administration. R1's medication administration record (MAR) dated August 1, 2025, through August 31, 2025, indicated R1 received the following medications: acetaminophen 500 milligram (mg) 2 tablets three	02320			

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02320	Continued From page 44 times daily, amlodipine 5 mg 1 tablet once daily, gabapentin 300 mg 1 capsule three times daily, haloperidol 5 mg 1 tablet once daily, Invega Sustenna 234 micro gram (mcg) injection into muscle 1 each month, methocarbamol 500 mg 1 and one-half tablet each day, tamsulosin 0.4 capsule once daily, hydromorphone 4 mg 1 - 1.5 tablets every four hours, hydroxyzine 25 mg 1 to 2 capsules every six hours as needed, and oxycodone 5 mg give 1 to 2 tablets by mouth every four hours as needed. On August 20, 2025, at 7:54 a.m., the surveyor observed ULP-A remove a medication card containing oxycodone 5 mg from a medication cabinet located on the lower level of the two story-home. R1 walked out of their room into the kitchen. Without verifying the medications against the MAR, ULP-A placed 1 oxycodone into R1's hand and R1 swallowed the medication. On August 20, 2025, at 7:56 a.m., ULP-A stated they were trained by the nurse to administer medications without following a list or verifying the medications. ULP-A stated the nurse trained them to follow the times written on the medication card. On August 20, 2025, at 8:28 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated staff were trained to follow the MAR and verify the medications prior to administration. On August 21, 2025, at 11:12 a.m. CNS/LALD-C stated they were unsure why ULP-A stated they did not have to verify the medications prior to administration. CNS/LALD-C stated you cannot give medications without following a MAR.	02320			

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02320	Continued From page 45 The license's Medication Management policy dated October 7, 2022, indicated staff should have access to the following information for administering medications: purpose, dosage, route, frequency, and instructions related to the medication and specific to the residents, as appropriate. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02320			



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

Food & Beverage Inspection Report

Page: 1

Establishment Info

ALLIANCE HOME HEALTH CARE LLC
803 WEEKS AVENUE SE
Minneapolis, MN 55414
Hennepin County
Parcel:

Phone:

License Info

License: HFID 38714

Risk:
License:
Expires on:
CFPM: VACANT
CFPM #: ; Exp:

Inspection Info

Report Number: F1029251112
Inspection Type: Full - Single
Date: 8/19/2025 Time: 11:44 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 3
Total Priority 3 Orders: 5
Delivery:

New Order: 2-100 Supervision

2-102.11D,E,F,G,H,I *Priority Level: Priority 2 CFP#: 1*

MN Rule 4626.0030DEFGHI The person in charge must be able to demonstrate their knowledge to the inspector of the importance of the following food handling procedures to preventing foodborne disease: handwashing; avoiding cross contamination; avoiding hand contact with ready-to-eat foods; time and temperature requirements for safely refrigerating, hot holding, cooling, and reheating TCS food; hazards of eating raw or undercooked meat, poultry, eggs, and fish; food temperatures and cooking times required to safely cook TCS food including meat, poultry, eggs, and fish; foods identified as major food allergens and the symptoms of an allergic reaction; identification of critical control points in a food service operation and steps to be taken to ensure the points are controlled.

COMMENT: STAFF INDICATED COOK TEMP FOR BEEF BURGERS TO BE 145F RATHER THAN 155F AND PROVIDED CORRECT POULTRY COOK TEMP ON 3RD GUESS. SAFE COOKING TEMPERATURES REVIEWED.

ESTABLISHMENT HAS SAFE COOKING TEMP CHART POSTED ON KITCHEN CABINET.

Comply By: 8/19/2025 Originally Issued On: 8/19/2025

New Order: 2-100 Supervision

2-102.12AMN *Priority Level: Priority 3 CFP#: 2*

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

COMMENT: NO MN CFPM. NAIMA A. HUSSEIN COMPLETED FOOD SAFETY COURSE ON FEBRUARY 28, 2023.

EMPLOY INDIVIDUAL WITH ACTIVE MN CFPM CERTIFICATE.

Comply By: 10/3/2025 Originally Issued On: 8/19/2025

New Order: 2-400 Hygienic Practices

2-401.12 *Priority Level: Priority 3 CFP#: 7*

MN Rule 4626.0110 Food employees experiencing persistent coughing, sneezing, or a runny nose must not work with exposed food; clean equipment, utensils and linens; or unwrapped single-service or single-use articles.

COMMENT: STAFF MEMBER WITH COLD-LIKE SYMPTOMS - RUNNY NOSE. STAFF MEMBER CLAIMED SYMPTOMS WERE A RESULT OF A FOOD ALLERGY FROM ITEMS HE CONSUMED THE PREVIOUS DAY. CAUSE OF SYMPTOMS NOT CONCLUSIVELY ELIMINATED AS PATHOGEN INDUCED . EXCLUDE SYMPTOMATIC STAFF MEMBER FROM FOOD AND BEVERAGE SERVICE.

Comply By: 8/19/2025 Originally Issued On: 8/19/2025

! New Order: 3-300B Protection from Contamination: cross-contamination, eggs3-302.11A(1) *Priority Level: Priority 1 CFP#: 15**MN Rule 4626.0235A(1)* Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

COMMENT: RAW SHELL EGGS NEXT TO APPLES AND SLICED CHEESE. BEEF CHUB NEXT TO SALAD DRESSINGS AND OTHER READY TO EAT ITEMS. SEPARATE RAW ANIMAL PROTEINS SAFELY AWAY FROM READY TO EAT FOODS.

*Comply By: 8/19/2025 Originally Issued On: 8/19/2025***New Order: 3-500C Microbial Control: date marking**3-501.17B *Priority Level: Priority 2 CFP#: 23**MN Rule 4626.0400B* Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

COMMENT: OPENED BAGS OF SLICED DELI MEAT AND SHREDDED CHEESE WITHOUT DATE MARKS. ITEMS KNOWN TO HAVE BEEN OPENED 8/17 AND 8/15, RESPECTIVELY. ENSURE REQUIRED ITEMS ARE DATE MARKED.

*Comply By: 8/19/2025 Originally Issued On: 8/19/2025***New Order: 4-200 Equipment Design and Construction**4-201.11GMN *Priority Level: Priority 3 CFP#: 47**MN Rule 4626.0506G* Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

COMMENT: POULTRY POT PIES IN REFRIGERATOR FROM YESTERDAY. DISCONTINUE PRACTICE WITHOUT COOLER LISTED FOR SANITATION BY AN ANSI ACCREDITED CERTIFYING BODY.

*Comply By: 8/19/2025 Originally Issued On: 8/19/2025***New Order: 5-200C Plumbing: Maintenance, fixture location**5-205.11AB *Priority Level: Priority 2 CFP#: 10**MN Rule 4626.1110AB* The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

COMMENT: UTENSILS IN HANDWASHING SINK. ONLY USE THE HANDWASHING SINK FOR HANDWASHING.

*Comply By: 8/19/2025 Originally Issued On: 8/19/2025***New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control**6-501.11 *Priority Level: Priority 3 CFP#: 55**MN Rule 4626.1515* Maintain the physical facilities in good repair.

COMMENT: MILLWORK WITH EXPOSED MDF. SEAL.

*Comply By: 7/31/2026 Originally Issued On: 8/19/2025***New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control**6-501.19 *Priority Level: Priority 3 CFP#: 53**MN Rule 4626.1555* Keep the toilet room doors closed except during cleaning and maintenance operations.

COMMENT: BATHROOM DOOR LEFT OPEN. NO CLEANING OR MAINTENANCE OCCURRING. CORRECTED DURING INSPECTION.

Comply By: 8/19/2025 Originally Issued On: 8/19/2025

Food & Beverage General Comment

Food and beverage inspection of facility performed as part of HRD nursing survey. Identified issues reviewed with staff and nurse surveyor. Establishment's kitchen is residential in nature and TCS foods are prepared only for same-day service. Establishment serves 4 clients and they are all part of a highly susceptible population.

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

I acknowledge receipt of the Metro District Office inspection report number F1029251112 from 8/19/2025

IBRAHIM WALAAL
LALD

Trevor McCliment
Trevor McCliment,
Public Health Sanitarian 3
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Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

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Establishment Info

ALLIANCE HOME HEALTH CARE LLC
Minneapolis
County/Group: Hennepin County

Inspection Info

Report Number: F1029251112
Inspection Type: Full
Date: 8/19/2025
Time: 11:44 AM

New Record: Product/Item/Unit: MILK ; **Temperature Process:** COLD HOLDING

Location: REFRIGERATOR at 40 Degrees F.

Comment:

Violation Issued?: No

New Record: Product/Item/Unit: BUTTER; **Temperature Process:** COOLING (PANCAKES FOR BREAKFAST)

Location: REFRIGERATOR at 48 Degrees F.

Comment:

Violation Issued?: No

New Record: Product/Item/Unit: POULTRY POT PIE; **Temperature Process:** COLD HOLDING

Location: REFRIGERATOR at 40 Degrees F.

Comment:

Violation Issued?: No



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Sanitizer Observations/Recordings

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Establishment Info	Inspection Info
ALLIANCE HOME HEALTH CARE LLC	Report Number: F1029251112
Minneapolis	Inspection Type: Full
County/Group: Hennepin County	Date: 8/19/2025
	Time: 11:44 AM

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine

Location: Kitchen **Equal To** 160 Degrees F.

Comment:

Violation Issued?: No