

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL355856902M
Compliance #: HL355851377C

Date Concluded: April 7, 2025

Name, Address, and County of Licensee

Investigated:

Alliance Homes Corporation
4946 Jackson Street NE
Columbia Heights, MN, 55421
Anoka County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Angela Vatalaro, RN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Visit:

The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):

The alleged perpetrator (AP), an unlicensed staff member, neglected the resident when the AP failed to ensure the resident's safety by checking water temperature prior to providing the resident a foot soak. The resident sustained a burn and required hospitalization.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident had neuropathy (nerve damage) from a previous stroke that affected feeling in his feet. The facility failed to assess the resident for foot soak

treatments, failed to obtain provider orders, failed to update the plan of care to include foot soaks, and failed to train staff specifically on how to provide the resident foot soaks. In addition, the facility failed to update the resident's provider the day the foot burn injury occurred and the following day when the resident's foot burn worsened. The resident sustained a partial thickness burn of his left foot and required hospitalization.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and the AP. The investigation included review of the resident records, hospital records, facility internal investigation, incident reports, a personnel file, and related facility policy and procedures. Also, the investigator observed the resident and facility staff.

The resident resided in an assisted living facility. The resident's diagnoses included a stroke and residual neuropathy (nerve damage). The resident's service plan indicated the resident required assistance with showers or baths. The resident's assessment indicated the resident experienced hand and foot nerve pain due to a previous stroke. The resident's orientation varied by the time of day.

The facility internal investigation and incident report indicted the resident had chronic leg and foot pain, took Tylenol, and sometimes soaked his feet in warm water. One day, the AP helped the resident set up water for soaking his feet. The resident sustained a burn injury after soaking his feet for 15 to 20 minutes. The resident did not feel the water was too hot. The AP and resident noticed the burn when they observed the injury after the resident removed his feet from the water. The AP reported she checked the temperature of the water while wearing surgical gloves.

Progress notes indicated the day of the injury the AP called the nurse and reported the resident's left foot was swollen after soaking in hot water. Upon arrival to the facility, the nurse assessed the burn and recommended the resident be evaluated at a hospital. The resident refused the hospital visit stating he had an appointment scheduled with his provider in two days and wanted to wait. The nurse spoke to the resident about the risk of not treating the burn right away. The next day, the nurse assessed the resident's foot. The area worsened and was "oozing." The nurse recommended an evaluation at a hospital a second time, but the resident refused stating the resident would see his provider the following day.

The facility failed to update the resident's medical provider the day the resident's burned his left foot and when the burn worsened the next day.

Records indicated two days after the burn, the resident was seen during his scheduled provider appointment. After the resident's provider saw the left foot burn, the resident was transferred to the hospital for treatment.

Hospital records indicated the resident had a history of a stroke and residual neuropathy. The resident presented to the emergency room for a foot burn. The resident put his left foot into

hot water two days prior and did not realize how hot it was due to his nerve damage. The resident sustained a large blister to his foot which had worsened and was painful. The resident was diagnosed with a partial thickness burn of his left foot. The resident required admission to the hospital for treatment of the left foot burn and possible infection, secondary to soaking his feet in hot water. The resident had swelling of his left foot, large tense blisters of the dorsal (top of foot) and plantar surface (bottom part of foot) extending towards the heel. A computerized tomography scan (CT) scan showed the resident had soft tissue swelling compatible with cellulitis (bacterial infection), extensive skin blistering of his plantar foot and dorsal forefoot, and a left foot abscess (collection of pus). Podiatry (foot provider) performed an incision with drainage procedure to drain pus twice during the resident's hospital stay. The resident was admitted to the hospital for seven days and discharged back to the facility in stable condition, on antibiotics, daily dressing changes, and follow-up appointments with the burn clinic.

During an interview, the AP stated she assisted the resident with a foot soak after the resident requested the soak. The water was from the bathroom sink tap and was put into a basin for the resident to soak his feet. The AP stated because she wore gloves when she checked the water she did not know the water was that hot. During the soak, the AP asked the resident how he was feeling, the resident told the AP he was "good" and "okay." Following the foot soak, the AP stated she contacted the nurse when she saw the resident had fluid filled areas of skin like burns on his left foot. The AP stated, staff had provided foot soaks to the resident prior to the incident. The AP said she was trained on providing resident showers and checking water temperature; however, she was not trained on providing the resident foot soaks.

The AP's training records did not include education, training, or competency on providing foot soaks.

During an interview, a nurse stated she was aware staff provided the resident foot soaks for comfort due to pain from his nerve damage. The nurse stated the day of the incident, the AP provided the resident a foot soak and the AP said she checked the water temperature while wearing a surgical glove. At some point during the soak, the resident felt warmth, and eventually took his foot out of the water. Both the AP and resident noticed a burn injury and the AP reported the injury to the nurse. The nurse stated she arrived at the facility within an hour and the resident's skin was red, swollen, intact, with no fluid filled blisters at that time. The nurse stated she cleaned the burn injury with rubbing alcohol and had the resident elevate his leg/foot. The nurse stated the resident refused to go to the emergency room and the next day, when the wound worsened, with the blisters oozing, the resident continued to refuse an evaluation at the emergency room. The nurse stated on the second day, she dried the burned area with gauze, and had the resident elevate his foot. The nurse stated she did not speak directly to the resident's provider regarding the resident's burn the day of the burn and the following day when the burn worsened. The nurse stated she contacted the clinic the day of the incident to check for an earlier appointment time. The nurse stated she had not encountered a situation when a resident refused a hospital visit when she felt the resident needed to be seen for treatment. The nurse stated the AP, and all the other staff were trained on water safety for

providing showers/baths however, staff did not receive training, demonstration, or competency on how to provide the resident's foot soaks prior to the incident. The nurse stated the resident's foot soaks were not assessed, or part of the resident care planned services.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.

"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17

"Neglect" means neglect by a caregiver or self-neglect.

(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

- (1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
- (2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: Yes.

Family/Responsible Party interviewed: No. Responsible for self.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

After the incident, staff received training and education on resident safety including checking water temperature using a naked hand or use of a thermometer. The AP is no longer employed by the facility.

Action taken by the Minnesota Department of Health:

The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

<https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html>

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email.

cc:

The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Anoka County Attorney
Columbia Heights City Attorney
Columbia Heights Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35585	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/18/2025
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NAME OF PROVIDER OR SUPPLIER ALLIANCE HOMES CORPORATION	STREET ADDRESS, CITY, STATE, ZIP CODE 4946 JACKSON STREET NE COLUMBIA HEIGHTS, MN 55421
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.</p> <p>INITIAL COMMENTS:</p> <p>#HL355851377C/#HL355856902M</p> <p>On February 18, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 4 residents receiving services under the provider's Assisted Living license.</p> <p>The following correction orders are issued for #HL355851377C/#HL355856902M, tag identification 1940 and 2360.</p>	0 000	<p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	
01940 SS=G	144G.72 Subd. 3 Individualized treatment or therapy managemen	01940		

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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01940	<p>Continued From page 1</p> <p>For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following:</p> <ul style="list-style-type: none"> (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all the required content for one of one resident (R1). The licensee failed to obtain orders for foot soaks, failed to assess R1 for foot soaks, failed to update the plan of care identifying foot soaks, and</p> 	01940		

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01940	<p>Continued From page 2</p> <p>failed to train staff specifically on R1's foot soaks. In addition, the licensee failed to update R1's provider when R1's foot burn injury occurred and failed to update R1's provider the day after when the foot wound worsened. R1 sustained a partial thickness burn of his left foot and hospitalized.</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at 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).</p> <p>The findings include:</p> <p>R1's diagnoses included CVA (cerebrovascular accident, stroke) with residual neuropathy (nerve damage).</p> <p>R1's assessment dated September 1, 2024, indicated R1 received assistance with showers or a bath. R1 reported hand and foot nerve pain following a stroke in 2019. R1's orientation varied by the time of day.</p> <p>R1's scheduled services dated October 20, 2021, indicated R1 required assistance with a shower or bath.</p> <p>R1's assessment and scheduled services record did not indicate R1 required or received staff assistance with foot soaks. R1's record indicated provider orders were not obtained to provide this treatment.</p> <p>R1's record lacked a treatment management plan</p>	01940		

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01940	<p>Continued From page 3</p> <p>to include the following required content for foot soaks:</p> <ul style="list-style-type: none"> - statement of the type of service that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed and monitoring of treatment or therapy to prevent possible complications or adverse reactions. <p>Review of the licensee's document titled Adverse Event Debriefing indicated on October 29, 2024, an adverse event took place. R1 had chronic leg pain. R1 took Tylenol and sometimes soaked his feet in warm water for comfort. On that day, unlicensed personnel (ULP-B) assisted R1 to set up for soaking his feet. The water that ULP-B set up was too hot as evidenced by the injury R1 sustained after soaking his feet for 15 to 20 minutes. Only after R1 removed his feet from the water, ULP-B saw the left foot injury. ULP-B reported she checked the temperature of the water while wearing a surgical glove.</p> <p>R1's incident report dated October 30, 2024, indicated R1 sustained a left foot burn due to soaking his feet in hot water. R1 refused to have 911 called saying he was going to see his doctor in two days and wanted to wait. The incident report indicated R1 refused to go to hospital. The</p>	01940		

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01940	<p>Continued From page 4</p> <p>same report indicated the licensee clean the resident' foot with alcohol and applied a dressing.</p> <p>R1's progress notes dated October 30, 2024, indicated unlicensed personnel (ULP)-B called registered nurse/licensed assisted living director (RN)-A to report R1's left foot was swollen after R1 soaked his feet in hot water. Upon arrival RN-A assessed R1's foot and recommended that R1 be evaluated at a hospital. R1 refused and stated he was going to see his regular doctor in two days and did not feel he needed to go the hospital. RN-A explained to R1 the risk of not treating the burn right away, again R1 refused to be evaluated at a hospital. RN-A treated the area with alcohol and put on a dressing.</p> <p>R1's progress notes dated October 30, 2024, did not indicate R1's provider was informed of R1's burn.</p> <p>R1's progress notes dated October 31, 2024, indicated R1 was assessed by RN-A. The progress notes indicated R1's left leg "seems worse and oozing" skin tears were noted. RN-A took a picture of the foot and showed this to R1 to convince R1 to go the hospital for an evaluation. R1 refused and wanted to wait to see his regular doctor the next day. RN-A changed the dressing.</p> <p>R1's progress notes dated October 31, 2024, did not indicate R1's provider was updated on R1's worsening burn.</p> <p>R1's after visit summary from the clinic visit dated November 1, 2024, indicated R1's provider observed R1's left foot burn.</p> <p>R1's progress notes dated November 1, 2024, indicated R1's provider convinced R1 to go to the</p>	01940		

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01940	<p>Continued From page 5</p> <p>hospital after the provider observed R1's left foot burn.</p> <p>R1's hospital records dated November 1, 2024, indicated R 1 was diagnosed with partial thickness burn of his left foot. R1 was admitted that day to the hospital with the left foot burn and possible infection, secondary to soaking his foot in hot water. The record indicated R1 had swelling of his left foot, large tense blisters of the dorsal (top of foot) and plantar surface (bottom part of foot) extending towards the heel. R1's computerized tomography scan (CT) showed soft tissue swelling compatible with cellulitis (bacterial infection), extensive skin blistering of his plantar foot and dorsal forefoot, and left foot abscess (collection of pus). Podiatry performed an incision and drainage procedure on November 2, and November 6, 2024, to drain pus. R1 discharged back to the licensee on November 8, 2024, in stable condition, on antibiotics, daily dressing changes, and follow-up with the burn clinic.</p> <p>R1's assessment dated November 8, 2024, did not indicate if R1 received foot soaks. R1 had residual neuropathy pain from his stroke. The same assessment indicated R1 had a left foot ulcer and burn wound.</p> <p>R1's care plan dated November 10, 2024, did not indicate if R1 received foot soaks. R1 required assistance with oral care, bathing, a shower three times a week, shampoo, and skin care. The care plan indicated staff would test water for safe use and would test warm water for safe use without gloves. R1's care plan did not include foot care and foot soaks.</p> <p>R1's vulnerability assessment dated November 10, 2025 [sic], indicated R1 had chronic</p>	01940		

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01940	<p>Continued From page 6</p> <p>conditions, pain, and disability from arthritis and neuropathy and had decreased sensation in his lower extremities due to R1's neuropathy.</p> <p>R1's after visit summary from a burn and wound clinic dated November 19, 2024, and November 25, 2024, indicated R1 was seen at the clinic for a deep partial thickness burns of his foot.</p> <p>On February 25, 2025, at 1:41 p.m., RN-A stated she was aware staff provided R1 foot soaks for comfort from foot pain. RN-A stated R1's feeling in his feet was compromised after his CVA. At times, R1 soaked his feet in water with Epsom salts. That day, RN-A stated ULP-B got water from the tap and soaked his feet in a basin. RN-A said at some point during the foot soak, R1 felt the warmth, and eventually took his foot out of the water. Once out of the water, ULP-B noticed the burn injury to R1's left foot and RN-A stated ULP-B called her within 15 minutes of the burn injury occurring. RN-A arrived within the hour to assess R1's burn. R1's skin was red, swollen, skin was intact, with no fluid filled blisters at that time. RN-A cleaned the foot injury with rubbing alcohol and left it open to air. R1 refused to go to the emergency room (ER). The next day, R1's wound worsened, and R1 had blisters. R1 refused, to be evaluated at an ER and said he would wait for his scheduled doctor's appointment the following day. RN-A said she called R1's provider's office to schedule an earlier appointment however, no appointment was available. RN-A did not speak to R1's provider to inform the provider of R1's worsening burn. The following day, RN-A brought R1 to his provider's scheduled appointment and the provider arranged for R1 to go directly to the ER. R1 was admitted to the hospital for the burn to his left foot. RN-A stated ULP-B said she tested the</p>	01940		

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01940	<p>Continued From page 7</p> <p>water while wearing a surgical glove. RN-A said ULP-B and all the other staff had training on water safety for providing showers/baths however staff, did not receive training, demonstration, or competency on how to provide R1 foot soaks prior to the incident. RN-A stated R1's foot soaks for pain and comfort were not on R1's assessment or in R1's scheduled services and not considered a therapy. RN-A stated she considered R1's foot soaks as part of a bath/shower service.,</p> <p>On February 26, 2025, at 9:29 a.m., RN-A stated the licensee did not have a policy for foot soaks.</p> <p>The licensee's policy titled Delegation of Assisted Living Tasks, dated August 1, 2021, indicated the clinician (Registered Nurse or licensed health professional) would complete an assessment of residents receiving delegated services prior to the initiation of those services. The clinician may delegate procedures according to the following: instructed the home health aide in the proper methods to perform the procedure with respect to each resident, the clinician provided the home health aide written instructions specific to the resident, the home health aide demonstrated to the clinician competence in the procedure, the procedure is documented in the residents clinical record, and the competence is documented in his/her personnel file.</p> <p>The licensee's policy titled Treatment and Therapy Management, dated August 1, 2021, indicated the RN would obtain orders or prescriptions for all treatments and therapies. The RN or licensed professional would prepare an individualized treatment or therapy management plan for resident receiving ordered or therapy services which addressed the type of service to</p>	01940		

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01940	Continued From page 8 be provided, procedures for monitoring treatment or therapies to prevent possible complications or adverse reactions, and identification of treatment or therapy tasks delegated to unlicensed personnel. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01940		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		