



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 24, 2025

Licensee
Alliance Healthcare LLC
7013 Grimes Avenue North
Brooklyn Center, MN 55429

RE: Project Number(s) SL40590015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license**. Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on May 21, 2025, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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.

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

Per 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 residents/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 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 the Department of Health within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



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

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40590	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2025
NAME OF PROVIDER OR SUPPLIER ALLIANZE HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 7013 GRIMES AVENUE NORTH BROOKLYN CENTER, MN 55429		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
0 000	Initial Comments ***ATTENTION*** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL40590015-0 On May 19, 2025, through May 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 two residents both of whom received services under the Provisional 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.		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480			

Minnesota Department of Health

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

TITLE

(X6) DATE

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

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated May 19, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480			

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480			
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of two residents (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 on September 6, 2024, for assisted living services.	0 630			

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0 630	Continued From page 4 R1's IAPP dated March 18, 2025, lacked the following information: - the person's risk of abusing other vulnerable adults; and - statements of the specific measures to be taken to minimize the risk of abuse to other vulnerable adults. On May 21, 2025, at 12:30 p.m., clinical nurse supervisor (CNS)-A stated they completed the assessment and thought they had included all the required content. CNS-A also stated R1 was likely at risk to abuse others especially verbally. The licensee's Individual Abuse Prevention Plan policy dated August 1, 2023, indicated the licensee will develop and implement an individual abuse prevention plan for each vulnerable adult. The policy also indicated the plan will contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including: a. other vulnerable adults, b. the person's risk of abusing other vulnerable adults, and c. statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following	0 680			

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0 680	Continued From page 5 requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are 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 plan (EPP) 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	0 680			

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0 680	Continued From page 6 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's EPP dated September 6, 2024, lacked evidence of the following required content: - the various probable risks/hazards by likelihood of occurrence; - EPP program patient population; - procedures for tracking of staff and patients; - primary/alternate means for communication; - methods for sharing information; - sharing information on occupancy/needs; and - LTC family notifications. On May 21, 2025, at 12:30 p.m., clinical nurse supervisor (CNS)-A stated the licensee was in the process of developing their EPP to meet the statute requirement. CNS-A also stated they had worked hard to have their EPP information this far, and that they were happy with their progress. The licensee's Emergency Management Policy dated August 1, 2024, indicated the licensee will have an identified plan in place to ensure the safety and well-being of residents and employees during periods of an emergency or a disaster that disrupts facility services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 775 SS=E	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the	0 775			

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0 775	Continued From page 7 State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On May 20, 2025, at 10:30 a.m., the surveyor toured the facility with clinical nurse supervisor (CNS)-A. During the facility tour, the surveyor observed the following: SMOKING MATERIAL DISPOSAL There was a shed constructed of wood in the backyard. The shed contained an accumulation of dried leaves and lumber. Inside the shed, there was a designated smoking area sign on the floor and a disposal container for smoking materials. During the facility tour interview on May 20, 2025, CNS-A verified the above listed smoking area observations. Designated smoking areas shall not be located in an area containing combustible materials as this creates a fire hazard. ELECTRICAL	0 775			

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0 775	Continued From page 8 In the mechanical room, a cover was not installed on the electrical wall outlet behind the water heater. During the facility tour interview on May 20, 2025, CNS-A verified the above listed electrical observation. COMBUSTIBLE STORAGE In the mechanical room, cardboard boxes and wood were stored under the stairs, creating a fire hazard. During the facility tour interview on May 20, 2025, CNS-A verified the above listed observations and stated these materials would be removed. EMERGENCY EXITS On the back of the building, an exit sign was posted above the sliding patio door. A security bar was installed in the patio door track which prevented the door from sliding open. CNS-A had to remove the bar before being able to open the door. Additionally, the posted floor plan dated October 13, 2023, labeled the sliding patio door as an exit. During the facility tour interview on May 20, 2025, CNS-A verified this patio door was designated as an emergency exit. The use of physical door barriers on designated exits would limit the ability of occupants to safely evacuate the building in the event of an emergency. TIME PERIOD FOR CORRECTION: Two (2) days	0 775			
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	0 810			

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0 810	Continued From page 9 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 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 observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with required content and maintain all parts of the plan as readily available. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	0 810			

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0 810	Continued From page 10 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 May 20, 2025, clinical nurse supervisor (CNS)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The emergency floor plans dated October 13, 2023, failed to accurately identify the location and number of resident sleeping rooms evident by the following: On May 20, 2025, at 10:30 a.m., the surveyor toured the facility with clinical nurse supervisor (CNS)-A. During the facility tour, the surveyor observed numbers posted at the resident sleeping room doors. The numbers at the resident room doors did not match the number labels on the posted emergency floor plans. Additionally, in the emergency preparedness survey binder, the numbers posted at the resident room doors did not match the number labels on the FSEP floor plans and the main level floor plans did not identify resident sleeping room 3. Record review of the available documentation indicated the licensee failed to maintain all copies of the FSEP floor plan as accurate evident by the following: The FSEP floor plans posted on the walls in the facility did not match the FSEP floor plans stored in the emergency preparedness survey binder. Record review of the available documentation indicated the licensee failed to identify the main exit for the facility on the FSEP floor plan evident by the lack of exit labels on the plans. Exit labels are required to be included on the floor plan to direct occupants to the exits in the event of an	0 810			

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0 810	Continued From page 11 emergency. Record review of the available documentation indicated the FSEP included standard resident evacuation procedures but failed to provide readily available procedures for the individualized unique needs of residents evident by the lack of these procedures in the plan. Blank emergency evacuation reports were stored with the FSEP in the emergency preparedness survey binder. During an interview on May 21, 2025, at 12:40 p.m., CNS-A verified the emergency evacuation reports stored with the FSEP were templates. CNS-A stated the individualized resident emergency evacuation procedures were normally stored with the FSEP in the binder, but these reports had been removed earlier in the week. CNS-A stated these procedures were also stored electronically in the resident care plans. All parts of the FSEP must be maintained as readily available for all staff accessibility. During an interview on May 21, 2025, at 12:40 p.m., CNS-A verified the FSEP required revision. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by:	0 970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40590	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2025
NAME OF PROVIDER OR SUPPLIER ALLIANZE HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 7013 GRIMES AVENUE NORTH BROOKLYN CENTER, MN 55429		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 970	Continued From page 12 Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's blank Residency Contract/Agreement included the following section which contained language waiving the licensee's liability for health, safety, or personal property of a resident: "INDEMNIFICATION: Resident will indemnify and hold harmless provider, its employees and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by resident of the rented premises or any other part of provider's property, or caused wholly or in part by an act or omission of resident or resident's guests or agents." "Liability: provider is not liable to resident or resident's guests for any injury, death or property damage occurring in the apartment unit or on provider's premises unless such injury, death or property	0 970			

Minnesota Department of Health

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0 970	Continued From page 13 damage occurs as the result of an equipment malfunction or hazardous conditions within the building not caused by the resident or resident's guests. Provider is also not liable for any injury, death or damage occurring as the result of resident's receipt of health-related, supportive or other services from third party providers. The provider may be liable to resident for its own negligent acts or those of its employees or agents." On May 21, 2025, at 12:30 p.m., clinical nurse supervisor (CNS)-A stated they had updated their contract. However, when the surveyor reviewed R1 and R2's contract the waiver language was still there. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic	01370			

Minnesota Department of Health

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01370	Continued From page 14 devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) 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; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, 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 two employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number	01370			

Minnesota Department of Health

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01370	Continued From page 15 of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-B started employment with the licensee to provide assisted living services on September 21, 2024. On May 20, 2025, at 9:55 a.m., the surveyor observed ULP-B and ULP-C transfer R1 to bed using a Hoyer lift. Then ULP-B assisted R1 to change their brief in bed. ULP-B's training record lacked the following required content: - documentation requirements for all services provided; - basic infection control, including blood-borne pathogens; - maintenance of a clean and safe environment; and - awareness of confidentiality and privacy. On June 20, 2025, at 11:20 a.m., ULP-B stated they were trained at hire, and that they had completed the training as nurse aide (NAR), however, their certification was expired. On May 21, 2025, at 12:30 p.m., clinical nurse supervisor (CNS)-A stated they thought ULP-B was trained and oriented at hire. CNS-A stated they could not find the training record for ULP-B. The licensee's Delegation of Assisted Living Services policy dated June 6, 2024, indicated all residents will receive quality service delivered by staff who are educated and competent in the delivery of the assisted living services. The policy lacked to include training in the missing topics	01370			

Minnesota Department of Health

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01370	Continued From page 16 above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and	01470			

Minnesota Department of Health

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01470	Continued From page 17 (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff received all required orientation topics before providing direct care services to residents for one of two employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01470			

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01470	Continued From page 18 resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-B started employment with the licensee to provide assisted living services on September 21, 2024. On May 20, 2025, at 9:55 a.m., the surveyor observed ULP-B and ULP-C transfer R1 to bed using a Hoyer lift. Then ULP-B assisted R1 to change their brief in bed. ULP-B's training record lacked the following required content: - overview of Assisted Living statutes; - review of provider's policies and procedures; - 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 June 20, 2025, at 11:20 a.m., ULP-B stated they were trained at hire, but could not remember the topics covered. On May 21, 2025, at 12:30 p.m., clinical nurse supervisor (CNS)-A stated they thought ULP-B was trained and oriented at hire. CNS-A stated they could not find the training record for ULP-B.	01470			

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01470	Continued From page 19 The licensee's Staff Orientation Policy and Procedure dated June 6, 2024, indicated the licensee would ensure all new staff are adequately prepared to provide safe, respectful, and person-centered care that aligns with Minnesota Statutes 144G, MDH requirements, CMS guidelines, OSHA standards, and the principles of the Office of Ombudsman for Long-Term Care. This orientation policy ensures full compliance with Minnesota Statutes 144G, Minnesota Department of Health (MDH) rules, Centers for Medicare & Medicaid Services (CMS) federal standards, OSHA training and workplace safety regulations, the Office of Ombudsman for Long-Term Care, and all applicable state and federal healthcare regulatory requirements in the United States. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			



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

Allianze Healthcare LLC
7013 Grimes Avenue North
Brooklyn Center, MN 55429
Hennepin County
Parcel:

Phone:

License Info

License: HFID 40590

Risk:
License:
Expires on:
CFPM: Simon Paye
CFPM #: 53805; Exp: 10/23/2027

Inspection Info

Report Number: F7994251022
Inspection Type: Full - Single
Date: 5/19/2025 Time: 11:27:17 AM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

! New Order: 3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(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 EGGS FOUND STORED ON TOP SHELF OF FRIDGE. MOVE EGGS TO THE LOWEST POSSIBLE SPOT IN FRIDGE.

Comply By: 5/19/2025 Originally Issued On: 5/19/2025

Food & Beverage General Comment

INSPECTION CONDUCTED IN THE PRESENCE OF HRD STAFF AND FINDINGS SHARED AT THE END OF INSPECTION.

WILL EMAIL SUPPORTING DOCUMENTS AND LINKS TO HRD STAFF AT THE END OF THE DAY.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

FLOOR IS VINYL, CABINETS ARE WOOD WITH HALLOWED ENCLOSED BASES, GRANITE COUNTER TOPS AND SMOOTH PAINTED CEILING. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT ANY TIME THERE IS FOUND TO BE A RISK OF CONTAMINATION OR CONCERN THE PHYSICAL FACILITIES WILL BE REQUIRED TO BE BROUGHT UP TO CODE.

TEMPERATURES:

VEGETABLE 40

SLICED MEAT 40

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 F7994251022 from 5/19/2025

Simon Paye

Crystal Elva, REHS, MS, BS

Public Health Sanitarian 3
651-201-3981
crystal.elva@state.mn.us

Minnesota (MDH) Version EH Manager; RPT: F7994251022		Food Establishment Inspection Report		Page 1 of 1	
 Metro District Office Minnesota Department of Health 625 Robert St N, PO BOX 64975 St Paul, MN 55164		No. of Risk Factor/Intervention/Violations		1	Date: 5/19/2025
		No. of Repeat Risk Factor/Intervention/Violations			Time: 11:27:17 AM
		Score (optional)			Dur: min
Establishment: Allianze Healthcare LLC		Address: 7013 Grimes Avenue North		City/State: Brooklyn Center, MN	
License/Permit #: HFID 40590		Permit Holder:		Zip: 55429	
		Purpose of Inspection: Full		Est. Type:	
				Risk Category:	
FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS					
Designated compliance status (IN, OUT, N/O, N/A) for each numbered item					
IN=in compliance OUT=not in compliance N/O=not observed N/A=not applicable					
Mark "X" in appropriate box for COS and/or R					
COS=corrected on-site during inspection R=repeat violation					
Compliance Status				COS	R
Supervision					
1	IN	Person in charge present, demonstrate knowledge and performs duties			
2	IN	Certified Food Protection Manager			
Employee Health					
3	IN	knowledge, responsibilities, and reporting			
4	IN	Proper use of restriction and exclusion			
5	IN	Response to vomiting, diarrheal events			
Good Hygienic Practices					
6	IN	Proper eating, tasting, drinking, tobacco use			
7	IN	No discharge from eyes, nose, and mouth			
Preventing Contamination by Hands					
8	IN	Hands clean and properly washed			
9	IN	No bare hand contact with RTE foods, alternatives			
10	IN	Adequate handwashing sinks supplied and access			
Approved Source					
11	IN	Food obtained from approved source			
12	N/O	Food Received at proper temperature			
13	IN	Food in good condition, safe & unadulterated			
14	N/A	Records available: shellstock tags, parasite dest.			
Protection From Contamination					
15	OUT	Food separated and protected			
16	IN	Food-contact surfaces; cleaned & sanitized			
17	IN	Proper Disposition of returned, previously served, reconditioned, & unsafe food			
GOOD RETAIL PRACTICES					
Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.					
Mark "X" or OUT in box if numbered item is not in compliance Mark "X" in appropriate box for COS and/or R COS=corrected on-site during inspection R=repeat violation					
Compliance Status				COS	R
Safe Food and Water					
30	N/A	Pasteurized eggs used where required			
31		Water & ice from approved source			
32	N/A	Variance obtained for specialized processing methods			
Food Temperature Control					
33		Proper cooling methods used; adequate equipment for temperature control			
34	N/A	Plant food properly cooked for hot holding			
35	IN	Approved thawing methods used			
36		Thermometers provided & accurate			
Food Identification					
37		Food properly labeled; original container			
Prevention of Food Contamination					
38		Insects, rodents, & animals not present; no unauthorized person			
39		Contamination prevented during food prep, storage, & display			
40		Personal cleanliness			
41		Wiping cloths: properly used & stored			
42		Washing fruits & vegetables			
Person in Charge (signature)					
Inspector (signature)					
Follow-up: Follow-up Date:					
Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health interventions are control measures to prevent foodborne illness or injury					
Proper Use of Utensils					
43		In-use utensils; Properly stored			
44		Utensils, equipment & linens; properly stored, dried, handled			
45		Single-use & single-service articles, properly stored and used			
46		Gloves used properly			
Utensils, Equipment and Vending					
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used			
48		Warewashing facilities: installed, maintained, used; test strips			
49		Non-food contact surfaces clean			
Physical Facilities					
50		Hot & cold water available; adequate pressure			
51		Plumbing installed; proper backflow devices			
52		Sewage & waste water properly disposed			
53		Toilet facilities; properly constructed, supplied & cleaned			
54		Garbage & refuse properly disposed; facilities maintained			
55		Physical facilities installed, maintained & clean			
56		Adequate ventilation & lighting; designated areas used			
57		Compliance with MCIAA			
58		Compliance with licensing and plan review			