Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 26, 2023

Licensee
Alliance Assisted Living Inc
2029 Pin Oak Drive
Eagan, MN 55122

RE: Project Number(s) SL36956015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 4, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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.

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

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

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

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

The correction order documentation should include the following:

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

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

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

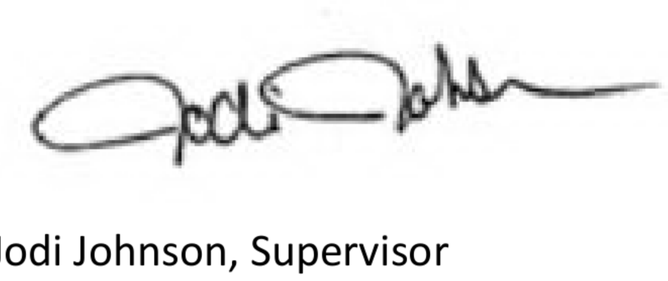
Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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,



Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36956	A. BUILDING: _____ B. WING _____	10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIANCE ASSISTED LIVING INC	2029 PIN OAK DRIVE EAGAN, MN 55122

(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: SL36956015 On October 2, 2023, through October 4, 2023, 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 active residents; two receiving services under the Assisted Living 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 License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

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0 470	Continued From page 1 (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 observation, interview, and record review, the licensee failed to ensure the required staffing plan was developed and posted as required, potentially affecting the licensee's current residents, staff, and any visitors of the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 470		

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0 470	Continued From page 2 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 held an assisted living license. The facility was licensed for a bed capacity of four residents and had a current census of two residents. The licensee lacked a daily staffing schedule developed by the clinical nurse supervisor and failed to develop and implement a staffing plan for determining its staffing level that: - include direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked; - identify the direct-care staff member's resident assignments or work location; - be posted after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location in each building; - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; - ensured 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 - ensured 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. During the entrance conference on October 2,	0 470		

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0 470	Continued From page 3 2023, at 11:28 a.m. licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated they were unsure if the facility had a staffing plan. LALD-A stated the facility had a minimum of one staff on each shift providing direct care; day shift: 7:00 a.m. - 12:00 p.m.; evening shift: 12:00 p.m. - 10:00 p.m.; and night shift: 10:00 p.m. - 7:00 a.m. On October 2, 2023, at 12:30 p.m. during the facility tour, the surveyor observed the entry and common areas within the facility with unlicensed personnel manager (ULPM)-C and noted there was no posting of the daily staffing schedule as required. ULPM-C stated they used to post the staffing hours though the posting was not present during the tour. On October 3, 2023, at 12:20 p.m. CNS-B stated they had not been posting the daily staffing schedule and further was unable to find evidence of a staffing plan and was unaware of the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced	0 480		

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0 480	Continued From page 4 by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated October 2, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management	0 580		

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0 580	Continued From page 5 must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of ongoing quality management activities relevant to the size and services provided by the assisted living provider. 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 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: During the entrance conference on October 2, 2023, at 11:28 a.m., the surveyor requested the licensee's quality management plan and meeting minutes. Clinical nurse supervisor (CNS)-B and unlicensed professional manager (ULPM)-C stated many of the facility's working documents had been discovered missing after the former licensed assisted living director was terminated. CNS-B and ULPM-C were unsure about a current quality management project. On October 3, 2023, at 11:30 a.m. CNS-B stated he was unable to find evidence of a quality management or meetings, although he had attended meetings in the past.	0 580		

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0 580	Continued From page 6 The licensee's 2.31 Quality Management Project policy dated August 1, 2021, indicated the licensee will have at least one documented quality management project in place at all times, and retain records of such projects for at least two years. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 650 SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057.	0 650		

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0 650	Continued From page 7 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for two of two employees (unlicensed personnel manager (ULPM)-C and ULP-D). 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 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: ULPM-C began providing direct care services for the licensee on February 10, 2021, and ULP-D began providing direct care services for the licensee on August 31, 2021. ULPM-C and ULP-D's records lacked an annual performance review that identified areas of improvement needed and training needs. On October 4, 2023, at 9:00 a.m. licensed assisted living director (LALD)-A stated being new to the position, though moving forward would be responsible for ensuring employee records contained all required content. LALD-A further stated ULPM-C and ULP-D's records did not include evidence of an annual performance review since hire.	0 650		

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0 650	Continued From page 8 The licensee's 4.05 Employee Records policy dated August 1, 2021, indicated employee records for each person will include documentation of annual performance reviews that identify areas of improvement needed and training needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers	0 660		

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0 660	Continued From page 9 for Disease Control and Prevention (CDC) which included documentation of a completed health history and symptom screen for one of two employees (unlicensed personnel (ULP)-D) and completion of a chest x-ray following a positive Quantiferon TB blood test for one of one employee (ULP manager (ULPM)-C). This had the potential to affect all current residents living in the facility. 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 TB facility risk assessment dated August 18, 2023, indicated the licensee was a low risk. ULP-D ULP-D was hired August 31, 2021, to provide direct care services. ULP-D's employee file lacked evidence of a TB symptom screen. ULPM-C ULPM-C was hired February 10, 2021, to provide direct care services. On October 3, 2023, at 8:31 a.m. ULPM-C was observed to administer oral medications to R1.	0 660		

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0 660	Continued From page 10 ULPM-C's provider progress note dated April 28, 2021, indicated ULPM-C was diagnosed with latent tuberculosis following a positive QuantiFERON gold blood test obtained at a pharmacy. A chest x-ray was ordered and was counseled on treatment which ULPM-C was agreeable to. ULPM-C's employee record lacked evidence of chest x-ray results following a positive QuantiFERON blood test collected February 4, 2021. On October 2, 2023, at 3:34 p.m. ULPM-C stated he completed the chest x-ray and also completed the prescribed treatment for latent tuberculosis. ULPM-C reviewed his employee file and stated the chest x-ray result was not in the file and thought that it was. On October 4, 2023, at 9:00 a.m. licensed assisted living director (LALD)-A reviewed ULPM-C and ULP-D's employee records and stated they did not include the above required content. The licensee's 8.16 Tuberculosis Screening policy dated August 1, 2021, indicated: Staff whose essential job functions require work within the same air space of home care clients will be screened and tested for tuberculosis prior to the staff being exposed to clients. Baseline (upon hire) screening will be completed, but serial (annual) screening will only be required with increased occupational risk or exposure. Screening will be conducted as follows: 1. New staff will be screened for active signs of TB using the Baseline TB Screening Tool for HCWs (health care workers). 2. New staff will have a IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool	0 660		

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0 660	Continued From page 11 for HCWs. 3. No staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is received and documented. 4. Staff TB screening results will be kept in each employee medical file. 5. Staff should be screened for signs and symptoms on an annual basis. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated an employee may begin working with residents after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. A HCW with a newly-identified positive TST or IGRA indicated before the HCW has direct patient contact, the following should be documented in their record: 1. Test result, 2. Assessment for current TB symptoms, 3. Chest X-ray to rule out infectious TB disease. The chest X-ray should be done after the date of the positive TST or IGRA; however, a chest X-ray done within the three months prior to the TST/IGRA is acceptable, provided that the HCW has not been exposed to infectious TB disease since the chest X-ray was done, and 4. Medical evaluation to rule out a diagnosis of infectious TB disease.	0 660		

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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
0 660	Continued From page 12 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are 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 develop an all-hazards risk assessment emergency preparedness program	0 680		

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	36956	A. BUILDING: _____ B. WING _____	10/04/2023

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0 680	Continued From page 13 and plan to include Appendix Z required elements. 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 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 the residents). The findings include: During the entrance conference on October 2, 2022, at 11:28 a.m., the surveyor asked for the licensee's emergency preparedness plan (EPP), which was provided and later reviewed by the surveyor. The licensee's plan lacked an all-hazards vulnerability assessment in addition to the following required content: - a description of the population served by the licensee; - process for emergency preparedness (EP) collaboration with state and local EP officials/organizations; - procedure for tracking staff and residents; - subsistence needs for staff and residents during emergency situations; - development of policies/procedures to address: - evacuation plan; - shelter in place; - the medical record documentation system to preserve resident information; - use of volunteers; - emergency staff strategies; and	0 680		

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0 680	Continued From page 14 - the facility's role in providing care and treatment at alternative sites. - a communication plan that included: - arrangement with other facilities; - names and contact information for resident physicians; - contact information for federal, state, tribal, local EP staff, or the ombudsman; - primary and alternative means for communicating with facility staff, or federal, state, regional and local - policies and procedures to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act -emergency management agencies; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and -a method of sharing information from the emergency plan with residents and their families. - EP training and testing program; - EP training program for staff (including documentation of training provided); and - EP testing/annual testing requirements. On October 2, 2023, at approximately 12:50 a.m. unlicensed personnel manager (ULPM)-C stated the licensee's previous licensed assisted living director (LALD) had been working on the EPP. ULPM-C further stated many documents were discovered missing after the previous LALD had been terminated including the EPP. The EPP provided to the surveyor was a template obtained from a provider organization, but had not yet been utilized to create their own plan. The licensee's 9.01 Emergency Preparedness	0 680		

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0 680	Continued From page 15 Plan - Appendix Z Compliance policy dated August 1, 2021, indicated the licensee's emergency preparedness plan will include all required elements of appendix Z. The plan will be in writing and reviewed annually. The plan is based on our assisted living-based and community-based risk assessments, utilizing an all-hazards approach. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the	0 730		

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0 730	Continued From page 16 resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (R3). 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).	0 730		

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0 730	Continued From page 17 The findings include: R3 was admitted to the licensee on December 12, 2021, with diagnosis of bipolar disorder. R3 discharged from the facility on July 6, 2022. R3's record lacked a discharge summary to include: - diagnoses; - allergies; - treatments and therapies; - pertinent lab, radiology, and consultation results; and - a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional status. On October 3, 2023, at 12:03 p.m. clinical nurse supervisor (CNS)-B stated being unable to locate R3's medical record and had to call R3's case manager to obtain the admission date, discharge date, and diagnosis. CNS-B further stated R3's medical record was probably with the former licensed assisted living director (LALD) as several documents were discovered missing after the former LALD was terminated. The licensee's 2.38 Resident Record - Information and Content policy dated August 1, 2021, indicated resident records must include: 14. A discharge summary, including service termination notice and related documentation, when applicable. No further information was provided. TIME PERIOD FOR CORRECTIONS:	0 730		

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0 730	Continued From page 18 Twenty-one (21) days	0 730		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810		

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0 810	Continued From page 19 This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to provide required employee and resident training on the fire safety and evacuation plan and failed to conduct required evacuation drills. This 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). Findings include: A record review and interview were conducted on October 3, 2023, at approximately 9:40 a.m. with Licensed Assisted Living Director (LALD)-A and Unlicensed Personnel Manager (ULPM)-C. on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training it initial hire. During interview, LALD-A stated being unable to locate any documentation on employee training on fire safety and evacuation plan. LALD-A stated they were new to the position and started August 14, 2023, and that it was assumed this documentation was taken from the facility by the recently terminated previous Licensed	0 810		

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0 810	Continued From page 20 Assisted Living Director. Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire to include movement, evacuation, or relocation as required by statute. During interview, LALD-A stated being unable to locate any documentation on employee training on fire safety and evacuation plan. LALD-A stated they were new to the position and started August 14, 2023, and that it was assumed this documentation was taken from the facility by the recently terminated previous Licensed Assisted Living Director. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. During interview, ULPM-C stated there were no documented drills and stated that the last drill conducted was in November of 2022. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01500 SS=E	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557;	01500		

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01500	Continued From page 21 (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training 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 challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations,	01500		

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01500	Continued From page 22 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 interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for two of two employees (unlicensed personnel manager (ULPM)-C and ULP-D). 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: ULPM-C was hired February 10, 2021, to provide direct care services. ULPM-C's employee record lacked evidence the employee had successfully completed annual training as required, to include the following: - Reporting maltreatment of vulnerable adults; - Assisted Living bill of rights; - Infection control techniques; - Review of provider's policies and procedures; and	01500		

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01500	Continued From page 23 - Principles of person-centered planning/service delivery ULP-D ULP-D was hired August 31, 2021, to provide direct care services. ULP-D's employee record lacked evidence the employee had successfully completed annual training as required, to include the following: - Reporting maltreatment of vulnerable adults; - Assisted Living bill of rights; - Infection control techniques; - Review of provider's policies and procedures; and - Principles of person-centered planning/service delivery On October 4, 2023, at 9:00 a.m. licensed assisted living director (LALD)-A reviewed ULPM-C and ULP-D's employee records and stated they did not contain the above required annual training. The licensee's Orientation & Training policy dated August 1, 2023, indicated: The following training elements MUST be included every 12 months to all staff who performs direct care services: 1. Training on reporting of maltreatment of vulnerable adults under section 626.557 2. Review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights 3. Review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and	01500		

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01500	Continued From page 24 equipment, such as dressing, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases 5. Review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures 6. Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01530 SS=E	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the	01530		

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01530	Continued From page 25 requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two employees (unlicensed personnel manager (ULPM)-C, ULP-D) completed at least two hours of dementia training annually as required. 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 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: ULPM-C ULPM-C was hired February 10, 2021, to provide direct care services. On October 3, 2023, at 8:31 a.m. ULPM-C was observed to administer oral medications to R1. ULPM-C's record identified annual dementia care topics were completed as follows: - 2022: April 19, 2022 - 0.5 hours completed - 2023: September 6, 2023 - 0.5 hours	01530		

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01530	Continued From page 26 completed. September 24, 2023 - 0.75 hours completed. ULPM-C's record lacked at least two hours of training on topics related to dementia for each 12 months of employment as required. ULP-D ULP-D was hired August 31, 2021, to provide direct care services. ULP-D's record identified annual dementia care topics were completed as follows: - 2022: April 22, 2022 - 0.5 hours completed - 2023: No training completed ULPM-C and ULP-D's records lacked at least two hours of training on topics related to dementia for each 12 months of employment as required. On October 4, 2023, at 9:00 a.m. licensed assisted living director (LALD)-A reviewed ULPM-C and ULP-D's employee records and stated they did not contain the required annual training for dementia. The licensee's 5.03 Dementia Training policy dated August 1, 2023, indicated all staff are required to complete dementia training at the time of hire and annually thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

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	36956	A. BUILDING: _____ B. WING _____	10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIANCE ASSISTED LIVING INC	2029 PIN OAK DRIVE EAGAN, MN 55122

(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
01620	Continued From page 27 (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) 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. (e) 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 the registered nurse (RN) conducted ongoing nursing assessments not to exceed 90 days for 1 of 1 resident (R1), and failed to include required areas of assessment per Assisted Living Facilities: Minnesota Rules Chapter 4659, for one of one resident (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	01620		

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01620	Continued From page 28 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: R1's diagnoses included diabetes and bipolar disorder. R1's Service Plan dated July 8, 2021, indicated the resident received services including medication administration, blood sugar checks, laundry, and light housekeeping. R1's last three assessments were requested. Assessments dated December 30, 2022, March 30, 2023, and June 28, 2023, were provided and reviewed by the surveyor on October 3, 2023. 97 days had passed since R1's last assessment dated June 28, 2023. In addition, the assessments did not include per Assisted Living Facilities: Minnesota Rules Chapter 4659.0150 Uniform Assessment Tool, the components required in subpart 2, section A, 1-3. On October 3, 2023, at 10:15 a.m. clinical nurse supervisor (CNS)-B stated a full comprehensive assessment was completed upon admission, updated at 14 days, then every 90 days thereafter or with a change of condition. CNS-B stated the comprehensive assessment was only completed upon admission, and all assessments thereafter only summarized any changes. CNS-B reviewed the requirements for the Uniform Assessment Tool and stated all of the 14-day, 90 day and change of condition resident assessments completed did not meet the required components for any of the residents.	01620		

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01620	Continued From page 29 The licensee's 6.01 Assessments, Reviews & Monitoring policy dated August 1, 2023, indicated the initial nursing assessment or reassessment must include all the elements of the uniform assessment tool as required. The Assisted Living Facilities: Minnesota Rules Chapter 4659.0150 Uniform Assessment Tool indicated: - Subpart 1. Definition. For purposed of this part, "Uniform Assessment Tool" means an assessment tool that meets the requirements of this part and is used by a licensee to comprehensively evaluate a resident's or prospective resident's physical, mental, and cognitive needs. - Subp. 2. Assessment tool elements. Each facility must develop a uniform assessment tool. The facility may use any acceptable form or format for the tool, such as an online or a hard-copy paper assessment tool, as long as the tool includes the elements identified in this subpart. A uniform assessment tool must address the following: A. the resident's personal lifestyle preferences, including: (1) sleep schedule, dietary and social needs, leisure activities, and any other customary routine that is important to the resident's quality of life; (2) spiritual and cultural preferences; and (3) advance health care directives and end-of-life preferences, including whether a person has or wants to seek a "do not resuscitate" order and "do not attempt resuscitation order or "physician/provider orders for life-sustaining treatment: order. No further information was provided.	01620		

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01620	Continued From page 30 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01650		

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01650	Continued From page 31 licensee failed to ensure a service plan included the correct required content for one of one resident (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 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: R1's diagnoses included diabetes and bipolar disorder. R1's Service Plan dated July 8, 2021, indicated the resident received services including medication administration, blood sugar checks, laundry, and light housekeeping. The service plan included a RN assessment would be conducted within the first five days of the initiation of services to determine needs and develop a service plan. The service plan identified an incorrect schedule and method of monitoring assessments of the resident. On October 3, 2023, at 11:12 a.m., clinical nurse supervisor (CNS)-B stated the above required content was incorrect in the service plan, and reflective of previous home care statutes. CNS-B also said the same service plan format was utilized for all residents. The licensee's 6.08 Service Plan policy dated August 1, 2023, indicated the service plan will include a schedule and method for the next	01650		

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01650	Continued From page 32 planed assessment or monitoring. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
01710 SS=F	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. 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) conducted a face-to-face medication management reassessment to include all required content for one of one resident (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 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: During the entrance conference on October 2,	01710		

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01710	Continued From page 33 2023, at 11:28 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to the residents at the facility. R1 had diagnoses including diabetes, hypertension (high blood pressure) and bipolar disorder. R1's Service Plan dated July 8, 2021, indicated the resident received services including medication administration. R1's medication administration record dated October 2023, included three oral anti-diabetic medications, three anti-hypertensive medications, two medications to prevent heart attacks and strokes, two medications to lower cholesterol, one antipsychotic, and two antidepressants. On October 3, 2023, at 8:31 a.m. ULPM-C was observed to administer oral medications to R1. R1's Medication Management Plan was last reviewed July 8, 2021. R1's record lacked evidence the RN conducted a review of all medications the residents were known to be taking include a review of the side effects and contraindications annually. On October 3, 2023, at 11:20 a.m. clinical nurse supervisor (CNS)-B stated R1 had not been reassessed by the RN annually and further stated was unaware of the requirement. The licensee's 7.01 Medication Management - Assessment, Monitoring & Reassessment policy dated August 1, 2023, indicated the licensee will monitor and reassess the resident's medication	01710		

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01710	Continued From page 34 management services as needed when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01830 SS=F	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to renew prescriptions at least every 12 months for one of one resident (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 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: R1's record lacked an annual renewal of prescriber orders for medications.	01830		

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01830	Continued From page 35 R1 was admitted on July 8, 2021, with diagnoses including diabetes, hypertension (high blood pressure), and bipolar disorder. R1's Service Plan dated July 8, 2021, indicated the resident received services including medication administration. On October 3, 2023, at 8:31 a.m. unlicensed personnel manager (ULPM)-C was observed to administer oral medications to R1. R1's medication administration record dated October 2023, included the following medications: - amlodipine (anti-hypertensive) 10 milligrams (mg) by mouth daily - aspirin (blood thinner) low dose 81 mg by mouth daily - atenolol (anti-hypertensive) 100 mg by mouth daily - citalopram (antidepressant) 40 mg by mouth daily - clopidogrel (Plavix-used to prevent heart attacks and strokes) 75 mg by mouth daily - hydrocholorothiazide (anti-hypertensive) 25 mg by mouth daily - glipizide ER (antihyperglycemic) 10 mg by mouth twice daily - metformin (antihyperglycemic) 1000 mg by mouth two times a day - mirtazapine (antidepressant) 7.5 mg by mouth at bedtime - fenofibrate (antihyperlipidemic) 145 mg by mouth daily - ibuprofen 400 mg by mouth every six hours as needed for pain R1's prescriber orders dated July 8, 2021, included:	01830		

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01830	Continued From page 36 - metformin 1000 mg by mouth two times a day - amlodipine 10 milligrams by mouth once daily - aspirin low dose 81 mg by mouth once daily with a meal - atenolol 100 mg by mouth once daily - clopidogrel 75 mg by mouth once daily - fenofibrate 145 mg by mouth once daily with a meal - glipizide ER 10 mg by mouth twice daily before meals - hydrocholorothiazide 25 mg by mouth once daily - ibuprofen 400 mg by mouth every six hours as needed for pain R1's prescriber orders dated July 27, 2021, included: - citalpram hdrobromide 40 mg by mouth every bedtime - mirtazapine 7.5 mg by mouth every bedtime R1's prescriber orders had not been updated annually. On October 3, 2023, at 11:20 a.m. clinical nurse supervisor (CNS)-B stated he obtained resident's signed physician orders upon admission and post hospitalization; any new orders were obtained from the pharmacy. CNS-B stated R1's prescriber orders had not been updated at least annually as required and further indicated he was not aware of this requirement. The licensee's 7.20 Medication & Treatment Orders policy dated August 1, 2021, indicated the licensed nurse will communicate with the prescriber to assure that the prescriber renews a medication or treatment/therapy order at least every 12 months, or more frequently as needed. No further information was provided.	01830		

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01830	Continued From page 37 TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed upon discharge, to document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged resident (R3).	01910		

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01910	Continued From page 38 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on October 2, 2023, at 11:28 a.m., clinical nurse supervisor (CNS)-B stated resident's medications were counted and documented upon discharge or if destroyed. R3 was admitted to the licensee on December 12, 2021, with diagnosis of bipolar disorder. R3 discharged from the facility on July 6, 2022. R6's record did not include a disposition of medications upon discharge. On October 3, 2023, at 12:03 p.m. clinical nurse supervisor (CNS)-B stated R3 received physician prescribed medications that were administered by facility staff, although was unable to locate R3's medical record. CNS-B further stated R3's medical record was probably with the former licensed assisted living director (LALD) as several documents were discovered missing after the former LALD was terminated. The licensee's Disposition and Disposal of Medications policy dated August 1, 2023, indicated upon disposition, the licensee will document the following information in the clinical record:	01910		

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01910	Continued From page 39 a. Name, strength, and prescription number of medication, as applicable b. Quantity c. Method of disposition or to whom the medications were given d. Date of disposition e. Names(s)/signature(s) of staff or other individuals involved in disposition f. If applicable, to whom the medications were given. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of one resident (R1) receiving treatments. 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	01970		

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01970	Continued From page 40 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: On October 3, 2023, at 8:52 a.m. unlicensed personnel manager (ULPM)-C was observed obtaining R1's blood sugar. R1 was admitted on July 8, 2021, with diagnoses including diabetes. R1's Service Plan dated July 8, 2021, indicated the resident received services including blood glucose checks. R1's medical record lacked evidence of a prescriber order for the blood glucose checks. On October 3, 2023, at 11:20 a.m. clinical nurse supervisor (CNS)-B reviewed R1's medical record and was unable to find evidence of a current physician order for R1's blood glucose checks. The licensee's 7.20 Medication & Treatment Orders policy dated August 1, 2021, indicated the licensed nurse will communicate with the prescriber to assure that the prescriber renews a medication or treatment/therapy order at least every 12 months, or more frequently as needed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *10/02/23*
Time: 13:30:00
Report: 1005231229

Food and Beverage Establishment Inspection Report

Location:
Alliance Assisted Living Inc
2029 Pin Oak Drive
Eagan, MN55122
Dakota County, 19

Establishment Info:
ID #: 0038631
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7637427284
ID #:

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

The following orders were issued during this inspection.

3-500C Microbial Control: date marking

3-501.17B ***** Priority 2 *****

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.

OPENED CONTAINERS OF MILK WERE NOT DATE-MARKED (THIS WAS THE ONLY TCS FOOD OBSERVED AT TIME OF INSPECTION THAT REQUIRED DATE-MARKING). MARK THE DATE FOODS ARE OPENED TO ENSURE THEY ARE USED OR DISCARDED WITHIN 7 DAYS. FACT SHEET LEFT ON SITE.

Comply By: 10/02/23

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

NO DEVICE ON SITE. DISCUSSED REQUIREMENT TO PROVIDE A MAXIMUM REGISTERING THERMOMETER OR TEMPERATURE SENSITIVE STRIPS TO ENSURE THE DISHWASHER IS PROVIDING A UTENSIL SURFACE TEMPERATURE OF 160 DEGREES F OR ABOVE.

Comply By: 10/09/23

Food and Equipment Temperatures

Process/Item: Cold Hold/2% MILK
Temperature: 38 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Type: Full
Date: *10/02/23*
Time: 13:30:00
Report: 1005231229
Alliance Assisted Living Inc

Food and Beverage Establishment Inspection Report

Process/Item: Cold Hold/WHOLE MILK
Temperature: 37 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

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

INSPECTION COMPLETED WITH SUPERVISOR AND REVIEWED WITH HRD NURSE EVALUATOR WENDY BUCKHOLZ.

DISCUSSED ORDERS ON REPORT AS WELL AS EMPLOYEE ILLNESS, GLOVE USE, DATE-MARKING, AND COOKING TEMPERATURES.

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

FLOORING IS WOOD, CABINETS ARE WOOD WITH HOLLOW BASE, COUNTERS ARE LAMINATE, AND THE CEILING HAS A POPCORN FINISH. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1005231229 of 10/02/23.

Certified Food Protection Manager BATHR-ULDHIN I. OMAR

Certification Number: FM117223 Expires: 06/12/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
FOUZI SHARIF
SUPERVISOR

Signed: _____
Jessica Davis
Public Health Sanitarian III
651-201-3961
jessica.davis@state.mn.us