



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 21, 2025

Licensee

Global Alliance Home Health
4833 Winnetka Avenue North
Crystal, MN 55428

RE: Project Number(s) SL35670015

Dear Licensee:

On March 25, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on September 27, 2024. This follow-up survey determined your facility had corrected all of the state correction orders issued pursuant to the September 27, 2024 survey.

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

Also, at the time of this follow-up survey completed on March 25, 2025, we identified the following violation(s):

0830-Local Laws Apply-144g.45 Subd. 3

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration

process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

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

We urge you to review these orders carefully. If you have questions, please contact Jess Schoenecker at 651-201-3789.

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

Sincerely,

A handwritten signature in black ink, appearing to read 'Jess', with a horizontal line extending to the right.

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35670	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/25/2025
NAME OF PROVIDER OR SUPPLIER GLOBAL ALLIANCE HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 4833 WINNETKA AVENUE NORTH CRYSTAL, MN 55428		
(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 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: SL#35670015-2 On March 24, 2025, to March 25, 2025, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on December 30, 2024. At the time of the survey, there were 4 active residents; 4 receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued and/or issued.	{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 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

Minnesota Department of Health

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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:	{0 480}	Not reviewed during this survey.		
{0 660} SS=E	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:	{0 660}			

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{0 660}	Continued From page 3	{0 660}	Not reviewed during this survey.		
{0 790} SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by:	{0 790}	Not reviewed during this survey.		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	{0 800}	Not reviewed during this survey.		

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

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0 830 SS=D	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to comply with all state and local governing laws, and codes for fire safety, building, and zoning requirements when the licensee failed to obtain the required permit for replacement of egress windows. 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: On March 24, 2025, from 12:00 p.m. to 12:45 p.m., the surveyor toured the facility with unlicensed personnel (ULP)-B. The surveyor confirmed that the window in resident room 3 had been replaced and met the minimum opening requirement.	0 830			

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0 830	Continued From page 6 On March 24, 2025, at 12:15 p.m., licensee had not provided evidence of a permit obtained for resident room 3's window replacement and licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A stated the licensee was unaware of the requirement to obtain a permit for resident room 3's window replacement. Minnesota Administrative Rule 1300.0120 dated March 31, 2020, indicated an owner or authorized agent who intends to construct, enlarge, alter, repair, move, demolish, or change the occupancy of a building or structure, or to erect, install, enlarge, alter, repair, remove, convert, or replace any gas, mechanical, electrical, plumbing system, or other equipment, the installation of which is regulated by the code; or cause any such work to be done, shall first make application to the building official and obtain the required permit. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 830			
{01060} SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated	{01060}			

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{01060}	Continued From page 7 and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by:	{01060}	Not reviewed during this survey.		
{01610} SS=F	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted	{01610}			

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{01610}	Continued From page 8 living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by:	{01610}	Not reviewed during this survey.		
{01640} SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.	{01640}			

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{01640}	Continued From page 9 (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by:	{01640}	Not reviewed during this survey.		
{01730} SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel;	{01730}			

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{01730}	Continued From page 10 (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by:	{01730}	Not reviewed during this survey.		
{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by:	{01880}			
{01890} SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed	{01890}			

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{01890}	Continued From page 11 by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by:	{01890}	Not reviewed during this survey.		
{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:	{01910}			



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February 11, 2025

Licensee

Global Alliance Home Health
4833 Winnetka Avenue North
Crystal, MN 55428

RE: Project Number(s) SL35670015

Dear Licensee:

On December 30, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on September 27, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the September 27, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on September 27, 2024, found not corrected at the time of the December 30, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0820 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (g)

The details of the violations noted at the time of this follow-up survey completed on December 30, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

We urge you to review these orders carefully. If you have questions, please contact Jess Schoenecker at 651-201-3789.

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

Sincerely,

A handwritten signature in black ink, appearing to read 'Jess', with a stylized flourish extending to the right.

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35670	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/30/2024
NAME OF PROVIDER OR SUPPLIER GLOBAL ALLIANCE HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 4833 WINNETKA AVENUE NORTH CRYSTAL, MN 55428		
(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL35670015-1 On December 30, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on September 27, 2024. At the time of the survey, there were three (3) residents; three receiving services under the Assisted Living license. As a result of the follow-up survey, the following order was reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter	{0 480}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 480}	Continued From page 1 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 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part	{0 480}			

Minnesota Department of Health

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{0 480}	Continued From page 2 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:	{0 480}	Not reviewed during survey.		
{0 660} SS=E	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:	{0 660}			

Minnesota Department of Health

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{0 790}	Continued From page 3	{0 790}			
{0 790} SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by:	{0 790}			
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	{0 800}	Not reviewed during survey.		
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment	{0 810}	Not reviewed during survey.		

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{0 810}	Continued From page 4 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans 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: 0 820 SS=D 144G.45 Subd. 2 (g) Fire protection and physical environment	{0 810}			
			Not reviewed during survey.		
		0 820			

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0 820	Continued From page 5 (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident rooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to affect some residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On December 30, 2024, the surveyor conducted a follow-up survey on orders issued pursuant to a survey completed on September 27, 2024. The	0 820			

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0 820	Continued From page 6 surveyor emailed the facility on December 30, 2024, at 8:26 a.m. to determine if the window had been repaired or replaced in unoccupied resident rooms 3. In an email response dated December 30, 2024, at 10:21 a.m. owner (O)-C indicated that the windows had been repaired and meet the minimum requirements. On December 30, 2024, at 12:50 p.m. the surveyor conducted a survey on site to verify the window in resident room 3 was repaired and met the minimum opening requirements. The surveyor asked licensed assisted living director/certified nurse supervisor (LALD/CNS)-A to open the egress window in resident room 3. The noncompliant measurement is as follows: Resident room 3: The window measured 18 inches clear width, 36 1/2 inches clear height, and 657 square inches total open area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. The deficient condition was verified by LALD/CNS-A. LALD/CNS-A stated that they would call their maintenance person to repair or replace the window.	0 820			
{01060} SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent	{01060}			

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{01060}	Continued From page 7 risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and	{01060}			

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{01060}	Continued From page 8	{01060}			
	This MN Requirement is not met as evidenced by:		Not reviewed during survey.		
{01610} SS=F	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by:	{01610}			
{01640} SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the	{01640}			

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{01640}	Continued From page 9 facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by:	{01640}	Not reviewed during survey.		
{01730} SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's	{01730}			

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{01730}	Continued From page 10 directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by:	{01730}			
{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.	{01880}	Not reviewed during survey.		

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{01880}	Continued From page 11 This MN Requirement is not met as evidenced by:	{01880}	Not reviewed during survey.		
{01890} SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by:	{01890}			
{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,	{01910}			

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{01910}	Continued From page 12 date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by:	{01910}	Not reviewed during survey.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 7, 2024

Licensee

Global Alliance Home Health
4833 Winnetka Avenue North
Crystal, MN 55428

RE: Project Number(s) SL35670015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 27, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

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

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

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or

financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a

hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:

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

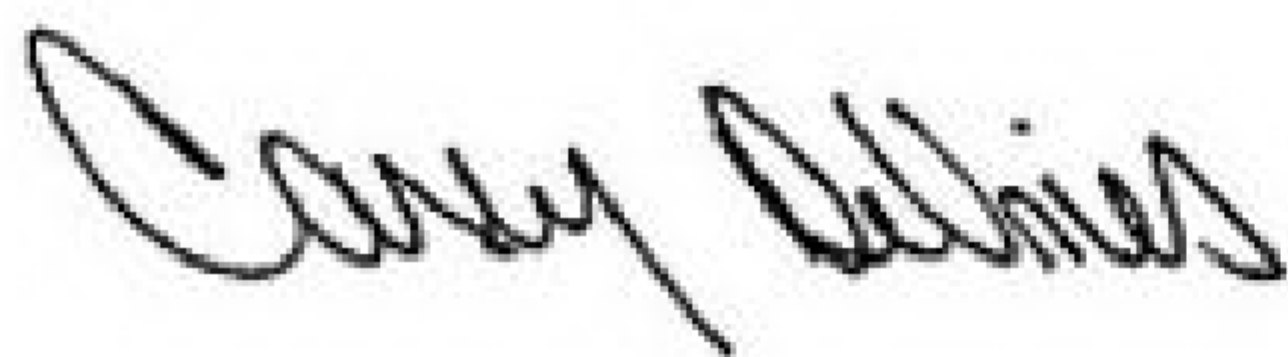
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEpHV>**. 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: 35670	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2024
NAME OF PROVIDER OR SUPPLIER GLOBAL ALLIANCE HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 4833 WINNETKA AVENUE NORTH CRYSTAL, MN 55428			
(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: SL35670015-0 On September 23, 2024, through September 27, 2024, 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 three residents; three of whom received services under the Assisted Living license. An immediate correction order was identified on September 23, 2024, issued for SL35670015-0, tag identification 1290. An immediate correction order was identified on September 24, 2024, issued for SL35670015-0, tag identification 0820.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35670	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2024
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0 480	Continued From page 1 (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 by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 24, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 660 SS=E	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control	0 660			

Minnesota Department of Health

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0 660	Continued From page 2 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 interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), to include TB testing upon hire for two of four employees (registered nurse (RN)-D, unlicensed personnel (ULP)-J). 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: On September 23, 2024, at 11:30 a.m., during the	0 660			

Minnesota Department of Health

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0 660	Continued From page 3 entrance conference, owner (O)-C stated new employees received two step skin testing for TB, with the first step completed prior to orientation. O-C stated if a new employee stated they had a history of positive skin testing but did not have results to demonstrate that, they would have them obtain a TB blood test and chest X-ray based on the results of the blood test. RN-D RN-D began employment with the licensee on June 12, 2020, to provide oversight to unlicensed personnel and direct services to residents. RN-D's employee record included completed health history and symptom screening, record of annual TB training, and chest X-ray results dated September 8, 2010, and June 28, 2015. RN-D's employee record lacked baseline TB testing completed on or within ninety days prior to their hire date with licensee and did not include any historical positive TB testing results that would indicate appropriateness of chest X-rays for monitoring. On September 26, 2024, at 10:40 a.m., O-C sent an email to the surveyor that indicated the licensee did not have record of a positive TB skin or blood test or a chest x-ray obtained within at least ninety days of hire for RN-D. ULP-J ULP-J had a hire date of October 25, 2022. ULP-J provided direct services to residents. ULP-J's employee record included completed health history and symptom screening and record of annual TB training. ULP-J's employee record lacked baseline TB testing completed on or within ninety days prior to their hire date with licensee.	0 660			

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0 660	Continued From page 4 On September 26, 2024, at 1:00 p.m., O-C stated via virtual meeting, the licensee did not have a record of TB testing for ULP-J. ULP-J was unable to locate a record of testing and had scheduled TB testing to be completed. The licensee's undated Tuberculosis Screening policy indicated all new employees would have documentation of baseline health symptom screening prior to providing direct care to residents. The screening would include, at minimum, the health symptom screening and TB skin or blood testing. Furthermore, all employee records would contain evidence of baseline TB screening consisting of a written assessment for current symptoms of active TB disease and testing for the presence of TB infection either by a two-step TB skin test or a single TB blood test. The policy indicated if the employee had proof of a TB blood test or negative chest X-ray within 90 days of employment, it did not have to be repeated at the time of hire. Regulations for Tuberculosis Control in Minnesota Health Care Settings: A guide for implementing tuberculosis infection control regulations in your facility, dated July 2013, indicated before the health care worker (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. If infectious TB	0 660			

Minnesota Department of Health

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0 660	Continued From page 5 disease is ruled out, additional chest X-rays are not needed unless the HCW develops symptoms of active TB disease or a clinician recommends a repeat chest X-ray, and 4. If the chest X-ray is done at the time of hire because documentation of a previous film was not available, a medical evaluation to rule out infectious TB disease should be done. No medical evaluation is required if HCW already has a chest X-ray dated after documented positive TST or IGRA. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect	0 790			

Minnesota Department of Health

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0 790	Continued From page 6 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 24, 2024, from 11:45 a.m. to 2:30 p.m., survey staff toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and registered nurse (RN)-D. The portable fire extinguishers throughout the facility lacked records to show monthly visual inspections were complete. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly. On September 24, 2024, at 2:15 p.m., surveyors explained to LALD/CNS-A that the portable fire extinguishers must have monthly visual inspections or "quick checks" of each extinguisher by their employees to ensure all portable extinguishers are readily available, fully charged, and operable at their designated location with no obvious physical damage or condition to the extinguisher that would prevent their operation when needed. LALD/CNS-A stated they understood the requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 790			

Minnesota Department of Health

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0 790	Continued From page 7 days	0 790			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 24, 2024, from 11:45 a.m. to 2:30 p.m., survey staff toured the facility with	0 800			

Minnesota Department of Health

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0 800	Continued From page 8 registered nurse (RN)-D and licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. The following was observed. EGRESS WINDOWS: In bedroom 2 the left egress window was missing the hand crank to operate the window. The hand crank for the right egress window was loose and made the window difficult to open. RN-D was advised that hardware would need to be maintained in operable condition. In bedroom 1 the right window was missing the hand crank to operate the window. RN-D stated that she would have maintenance install a new handle. GENERAL MAINTENANCE: The ceiling in the laundry room had a piece of joint tape that become loose and was hanging down from the ceiling. There was an approximately four-inch hole in the garage foundation on the left side of the overhead door. On September 24, 2024, at 2:15 p.m., LALD/CNS-A stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:	0 810			

Minnesota Department of Health

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0 810	Continued From page 9 (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. 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 the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors.	0 810			

Minnesota Department of Health

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0 810	Continued From page 10 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 24, 2024, licensed assisted living director/clinical nurse supervisor (LALD/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 licensee's FSEP, titled "Fire Safety", and "9.06 Fire Policy" failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35670	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2024
NAME OF PROVIDER OR SUPPLIER GLOBAL ALLIANCE HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 4833 WINNETKA AVENUE NORTH CRYSTAL, MN 55428			
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0 810	Continued From page 11 evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. On September 24, 2024, at 2:15 p.m., LALD/CNS-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. The policy reviewed was an unedited policy purchased from a third-party provider that was not specific to the facility. LALD/CNS-A stated that existing policy was incomplete and that they were working on building new policies. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD/CNS-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD/CNS-A lacked documentation showing any training was offered or training was scheduled for a future date for staff on the fire safety and evacuation plan. On September 24, 2024, at 2:15 p.m.,	0 810			

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0 810	Continued From page 12 LALD/CNS-A stated the fire safety training was provided by a third-party online software that could not be modified to include the facility-specific fire safety plans. LALD/CNS-A stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. LALD/CNS-A lacked documentation showing any evacuation drills had been completed. On September 24, 2024, at 2:15 p.m., LALD/CNS-A stated there were no additional documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
0 820 SS=G	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction.	0 820			

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0 820	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to affect some residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On September 24, 2024, from 12:00 p.m. to 1:00 p.m., the surveyor toured the facility with registered nurse (RN)-D. During the tour, the surveyor asked RN-D to open the windows in the resident bedrooms for measurement. The noncompliant measurements were as follows: OCCUPIED SLEEPING ROOMS: Bedroom 3: Two windows measuring 18 inches clear width, 36 1/2 inches clear height, and 657 square inches total open area for each window. The windows in bedroom 3 did not meet the minimum requirements for opening width. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and	0 820			

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0 820	Continued From page 14 minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. The surveyor explained to RN-D that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. On September 24, 2024, the surveyor explained to RN-D that an immediate correction order was issued for the above findings. RN-D stated they understood the requirements for egress windows. TIME PERIOD FOR CORRECTION: Immediate.	0 820			
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement	01060			

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01060	Continued From page 15 that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation for one of one resident (R4). 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	01060			

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01060	Continued From page 16 a large portion or all of the residents). The findings include: R4 was admitted to the licensee and began receiving assisted living services on May 10, 2022. R4's diagnoses included hypothyroidism, major depressive disorder, fetal alcohol spectrum disorder, and seizure disorder. R4's Service Plan, dated April 2, 2024, indicated R4 received medication set up and administration, assistance with bathing, dressing, grooming, housekeeping, laundry, meal preparation, transportation, shopping, socialization, and behavior management. R4's Resident Profile Notes, dated January 20, 2024, indicated R4 was admitted to a hospital for low potassium levels. R4's Assessment, dated January 29, 2024, indicated R4 had returned to the facility following their hospitalization. On January 22, 2024, at 10:35 a.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A completed an emergency relocation document in R4's electronic medical record. The document included: - the date and reason for the relocation; - the name and contact information for the acute care hospital R4 had been relocated to; - contact information for OOLTC; - that the estimated length of stay was unknown; and - a statement that, if the facility refuses to provide housing or services after a relocation, the	01060			

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01060	Continued From page 17 resident has the right to appeal under section 144G.54. The facility provided contact information for the agency to which the resident may submit an appeal. R4's record lacked confirmation that a written notice was delivered to R4, R4's guardian, and R4's waived services case manager. In addition, R4's record lacked notification to OOLTC when R2 did not return to the facility within four days. On September 27, 2024, at 12:40 p.m., via email, the OOLTC, indicated they had not received notification of R4's hospitalization in January of 2024. On September 27, 2024, at 9:03 a.m., LALD/CNS-A stated they initiated the emergency relocation form in the electronic medical record but did not distribute the information in writing to the resident, waived services case manager, or the ombudsman. LALD/CNS-A stated they provided the written notification to R4's guardian but that it had not been documented. LALD/CNS-A stated they were not aware who the notification needed to be provided to and the need to notify the ombudsman at the time of R4's hospitalization. The licensee's undated Assisted Living Contract Terminations policy indicated in the event of an emergency relocation the facility would provide a written notice that contained: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of	01060			

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01060	Continued From page 18 Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 1440.54; the facility must provide contact information for the agency to which the resident may submit an appeal. The policy indicated the notice of emergency relocation would be delivered as soon as practicable to the resident, legal representative, designated representative, and, if applicable, the resident's waived services case manager, and if the resident did not return to the facility within four days, the facility would also notify the Office of the Ombudsman for Long-Term Care. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith	01290			

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01290	Continued From page 19 reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license prior to staff providing services for six of ten employees (unlicensed personnel (ULP)-B, ULP-F, ULP-G, ULP-H, ULP-I, and ULP-J). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 23, 2024, at 12:50 p.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A provided the surveyor with schedule of ULPs working in the month of September 2024. The schedule included ULP-B, ULP-F, ULP-G, ULP-H, ULP-I, and ULP-J. On September 23, 2024, at 1:15 p.m., LALD/CNS-A provided the surveyor with a document titled Staff List- by Hire Date generated from the licensee's electronic medical record (EMR). LALD/CNS-A had three names crossed out and confirmed the rest of the names on the	01290	During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.		

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01290	Continued From page 20 document were current employees working in the facility. The list included ULP-B, ULP-F, ULP-G, ULP-H, and ULP-I. ULP-J was not included on the list. LALD/CNS-A stated they were not sure why they were not listed but confirmed they were actively working. ULP-B ULP-B was hired to provide assisted living services on November 1, 2023. On September 23, 2024, at 12:30 p.m., the surveyor observed ULP-B socializing with R3 in the facility dining room. On September 23, 2024, NETStudy 2.0 (a web-based system used to submit background study requests to the Department of Human Services (DHS)) indicated a background study for ULP-B was completed for the licensee's previous comprehensive health facility identification number (HFID) 35075 on August 12, 2020. NETStudy 2.0 indicated ULP-B was separated from HFID 35075 on December 29, 2023. ULP-F ULP-F was hired to provide assisted living services on August 9, 2023. On September 23, 2024, NETStudy 2.0 indicated a background study for ULP-F was completed for HFID 35075 on August 7, 2023, and separated on August 22, 2024. Another background study for ULP-F was completed for the HFID 35075 on November 7, 2023, and ULP-F was separated from HFID 35075 on December 29, 2023. ULP-G ULP-G was hired to provide assisted living services on April 18, 2023.	01290			

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01290	Continued From page 21 On September 23, 2024, NETStudy 2.0 indicated a background study for ULP-G was completed for a previously licensed affiliated sister facility HFID 36017 on April 17, 2023. This study was still listed as affiliated; however, the facility was closed. In addition, NETStudy 2.0 indicated a background study for ULP-G was completed for the licensee's previous comprehensive HFID 35075 on October 24, 2023. ULP-G was separated from HFID 35075 on December 29, 2023. ULP-H ULP-H was hired to provide assisted living services on July 15, 2023. On September 23, 2024, NETStudy 2.0 indicated a background study for ULP-H was completed for HFID 35075 on October 23, 2023, and separated on December 29, 2023. ULP-I ULP-I was hired to provide assisted living services on May 26, 2023. On September 23, 2024, NETStudy 2.0 indicated a background study for ULP-I was completed for HFID 35075 on May 25, 2023, and ULP-I was separated from HFID 35075 on December 29, 2023. ULP-J ULP-J was hired to provide assisted living services on October 25, 2022. On September 23, 2024, NETStudy 2.0 indicated a background study for ULP-J was completed for the licensee's current HFID 35670 on October 25, 2022, and separated on November 9, 2022. A background study for ULP-J was completed for	01290			

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01290	Continued From page 22 the licensee's previous comprehensive HFID 35075 on November 7, 2023, and separated from on December 29, 2023. On September 23, 2024, at 11:30 a.m., during entrance conference registered nurse (RN)-D stated new employee background studies were completed at the corporate office with clearance results confirmed prior to the employee beginning orientation or ever going to the facility. On September 23, 2024, at 2:15 p.m., owner (O)-C stated they were on the phone with NETStudy 2.0 technical support because they were not able to access the employee background study roster. The surveyor requested to view the roster of background studies for HFID 35670 with O-C when they resolved the access issue. On September 23, 2024, at 2:40 p.m., LALD/CNS-A stated background studies for new employees and maintaining the NETStudy 2.0 Roster were O-C's responsibility. LALD/CNS-A stated the corporate office completed all pre-hire activities including background studies prior to the new employee starting at the facility. LALD/CNS-A stated when a new hire started at the facility it was their understanding background study clearance had been received. Employee files were maintained at the corporate office. On September 23, 2024, at approximately 3:00 p.m., via telephone interview, O-C stated they were currently the person responsible for background studies for new employees. O-C stated it had been RN-E until O-C took it over around two years ago. O-C stated they recalled some communication from NETStudy 2.0 about HFID 35075 being removed. O-C stated they	01290			

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01290	Continued From page 23 were not aware of the HFID 35670 having a roster. O-C stated they thought when HFID 35075 was removed it would be replaced by a new one. O-C stated since the roster was still accessible, O-C continued to use it for background studies. O-C stated they did not know what happened but might have missed some communication while traveling out of state. On September 23, 2024, at 4:45 p.m, via telephone interview, O-C stated they did not have access to HFID 35670 at all on NETStudy 2.0. O-C stated it was not listed as an option and they were not able to search for it. They stated they planned to call DHS back first thing in the morning to gain access. On September 23, 2024, at 6:07 p.m., O-C stated, via telephone interview that when they attempted to log into NETStudy 2.0 earlier in the day on September 23, 2024, they were not able to view any rosters affiliated with this licensee including HFID 35075. The licensee's undated Background Studies policy indicated each employee who will provide direct care must have a background study completed and may not work until the results of the background study have been received. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290			
01610 SS=F	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an	01610			

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01610	Continued From page 24 initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed an initial comprehensive assessment of the physical and cognitive needs of the resident on or before the date of admission for three of three residents (R3, R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R3 R3 was admitted to the licensee and began receiving assisted living services on September	01610			

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NAME OF PROVIDER OR SUPPLIER GLOBAL ALLIANCE HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 4833 WINNETKA AVENUE NORTH CRYSTAL, MN 55428			
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01610	Continued From page 25 16, 2022. R3's Service Plan, dated July 2, 2024, indicated R3 received medication set up and administration, assistance with transfers, ambulation, bathing, dressing, grooming, housekeeping, laundry, meal preparation, shopping, and socialization. R3's Admission Assessment dated September 19, 2024, was completed three days after R3's admission. R4 R4 was admitted to the licensee and began receiving assisted living services on May 10, 2022. R4's Service Plan, dated April 2, 2024, indicated R4 received medication set up and administration, assistance with bathing, dressing, grooming, housekeeping, laundry, meal preparation, transportation, shopping, socialization, and behavior management. R4's Admission Assessment dated May 11, 2022, was completed one day after R4's admission. R5 R5 was admitted to the licensee and began receiving assisted living services on December 12, 2022. R5's Service Plan, dated December 12, 2022, indicated R5 received medication set up, administration, and reminders, assistance with transfers, bathing, grooming, housekeeping, laundry, meal preparation, shopping, transportation, and socialization.	01610			

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01610	Continued From page 26 R5's Admission Assessment dated December 14, 2022, was completed two days after R5's admission. On September 26, 2024, at 9:09 a.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A stated they start the assessment process on the day the resident moves in. They thought they had a period of up to five days to continue to gather information and complete the admission assessment. LALD/CNS-A stated they were not aware the assessment must be completed on or before when the resident moved in. The licensee's undated Nursing Assessment and Reassessment of Residents policy indicated the RN would conduct an initial nursing assessment prior to the date on which a resident executes a contract with a facility or the day the resident moves in, whichever is earlier. In addition, the initial assessment would be completed prior to the initiation of any delegated nursing services by unlicensed personnel and prior to the initiation of delegated treatments or assigned therapy tasks by unlicensed personnel. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610			
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must	01640			

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01640	Continued From page 27 include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to execute a signed service plan to include services being provided by the licensee for three of three residents (R3, R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R3 R3 was admitted to the licensee and began	01640			

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01640	Continued From page 28 receiving assisted living services on September 16, 2022. R3's diagnoses included Type II Diabetes, major depressive disorder, arteriosclerotic cardiovascular disease, and hypertension. R3's Service Plan, dated July 2, 2024, was signed by R3 and licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A and indicated R3 received the following services: - housekeeping daily; - home making weekly; - laundry two times weekly and as needed; - shopping weekly and as needed; - assistance making appointments weekly and as needed; - home management: arranging non-medical transportation weekly and as needed; - one to one socialization two times daily; - three meals and three snacks daily, - arrange non-medical transportation including driver, 1:1 , mileage 1:1, driver- riders 3 to 5 two times weekly; - dressing two times daily and as needed; - grooming two times daily and as needed; - bathing two times weekly; - assistance with incontinence daily checks and reminders; - stand by assistance with ambulation daily; - encouragement for R3 to use their walker daily; - assistance with transfers daily as needed; - assistance with medication administration/ self-administration three times daily and as needed; - verbal or visual medication reminders three times daily and as needed; - insulin injection daily; - delegated task of skin audit without a frequency listed;	01640			

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01640	Continued From page 29 - delegated task of Covid-19 monitoring without a frequency listed; - delegated task of blood glucose monitoring two times daily; - delegated task of blood pressure monitoring without a frequency listed; - medication set up and monitoring daily; - daily monitoring and management of orientation issues; - daily monitoring and management of anxiety; - daily monitoring and management of repetitive behavior; - daily monitoring and management of agitation; - daily monitoring and management of verbal aggression; and - daily monitoring and management of physical aggression. R3's Service Recap Summary, dated September 2024, was a document generated by the electronic medical record (EMR) that listed timed care services for facility employees to provide for R3. Employee initials on the document indicated the services were provided. R3 received the following services that were not included in R3's Service Plan: - change continuous glucose monitor sensor every fourteen days; - monitor oxygen saturation percentage daily; - monitor temperature, pulse, and respirations daily; - monitor behavior for delusions and accusations twice daily; - monitor for behavior of property destruction twice daily; - manage resistance to cares twice daily; and - manage self-injurious behavior twice daily. Additionally, R3's Service Plan and Service Recap Summary each included the following	01640			

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01640	Continued From page 30 services, but the frequency varied between the service plan direction and documentation of how often the services were provided: - the Service Plan indicated blood pressure monitoring was occurring but lacked frequency of monitoring, the Service Recap Summary indicated blood pressure monitoring occurred once daily; and - the Service Plan indicated snacks three times daily, the Service Recap Summary indicated snacks twice daily at AM and overnight. R3's Service Plan also indicated R3 received the following services related to medication management: - medication set up one time per day with a fee for service of \$28.54 per day; - medication administration three times daily and as needed with a fee for service of \$28.81 per day; - verbal or visual medication reminders three times daily and as needed with a fee for service of \$13.05 per day; and - insulin injection daily with a fee for service of \$14.41 per day. On September 23, 2024, at 12:30 p.m., during the facility tour, the surveyor observed the house medication cabinet to include a set up medication box labeled for R3 8:00 a.m., 5:00 p.m., and 8:00 p.m. The 8:00 a.m. and 8:00 p.m. boxes contained medications. The 5:00 p.m. boxes were all empty and a fourth row of boxes without a time label were all empty. LALD/CNS-A stated they set up medications for R3 weekly every Monday. The service recap summary and September 2024 MAR indicated medication administration six times daily at "AM", 8:00 a.m., 9:00 a.m., 10:00	01640			

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01640	Continued From page 31 a.m., 8:00 p.m., and "bedtime". On September 24, 2024, at 8:07 a.m., the surveyor observed ULP-B prepare and administer R3's medications. The medications administered were scheduled at 8:00 a.m. and 9:00 a.m., on the September 2024 MAR. ULP-B removed all the medications from a pill box that LALD/CNS-A had set up. The medications were all in a box labeled for Wednesday at 8:00 a.m. ULP-B stated they always gave all R3's morning medications together at the same time and not in two separate medication passes at 8:00 a.m. and 9:00 a.m. On September 24, 2024, at 12:00 p.m., LALD/CNS-A stated they set up medications for R3 weekly and R3 received medication administration twice daily in the morning and at bedtime. LALD/CNS-A stated they might have included the weekly injection as a third medication pass when they developed the service plan. LALD/CNS-A stated they had included three daily medication reminders on the service plan for offering as needed medications and going back multiple times if R3 refused to take their scheduled medications but agreed those situations were not medication reminders and R3 did not receive medication reminders. LALD/CNS-A stated the service plan should indicate weekly medication set up, twice daily medication administration, and no medication reminders. The service plan indicated R3 received a daily insulin injection. R3's Provider Orders, signed by the medical provider on August 26, 2024, did not include any insulin orders. The orders did include Bydureon BCise injectable, a diabetic medication glucagon like peptide- one (GLP-1) receptor agonist medication class. Bydureon BCise was	01640			

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01640	Continued From page 32 ordered on January 16, 2024, to be administered via subcutaneous injection once weekly for R3. R3's medication administration record (MAR), dated September 2024, indicated Bydureon BCise had been administered weekly as ordered. The MAR did not include any daily insulin injections. On September 25, 2024, at 12:00 p.m., LALD/CNS-A stated R3 had not had an order for a daily insulin injection while on services with licensee. LALD/CNS-A stated R3 had received the weekly Bydureon BCise injection, and the service plan should have indicated a weekly injection instead of daily. R4 R4 was admitted to the licensee and began receiving assisted living services on May 10, 2022. R4's diagnoses included hypothyroidism, major depressive disorder, fetal alcohol spectrum disorder, and seizure disorder. R4's Service Plan, dated April 2, 2024, was signed by R4's guardian and LALD/CNS-A and indicated R4 received the following services: - housekeeping daily; - home making weekly; - laundry two times weekly and as needed; - shopping weekly and as needed; - assistance making appointments one time monthly and as needed; - home management: arrange non-medical transportation weekly and as needed; - one to one/ two to five socializations two times daily; - three meals and two snacks daily, - arrange non-medical transportation including	01640			

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01640	Continued From page 33 driver, 1:1 , mileage 1:1, driver 2, mileage, driver 3-5 two times weekly; - dressing two times daily and as needed; - grooming two times daily and as needed; - bathing two times weekly; - assistance with medication administration/ self-administration three times daily and as needed; - verbal or visual medication reminders three times daily and as needed; - delegated clinical monitoring for choking without a frequency listed; - delegated clinical monitoring for skin audit without a frequency listed; - medication set up and monitoring daily; - daily monitoring and management of orientation issues; - daily monitoring and management of anxiety; - daily monitoring and management of repetitive behavior; - daily monitoring and management of self-injurious behavior; and - daily monitoring and management of agitation. R4's Service Recap Summary, dated September 2024, indicated R4 received the following services that were not included in R4's service plan: - monitor oxygen saturation percentage daily; - monitor blood pressure twice daily; - monitor temperature, pulse, and respirations twice daily; - record weight monthly; - monitor behavior for physical aggression twice daily; - monitor for behavior of property destruction twice daily; - manage verbal aggression twice daily; and - monitor for wandering twice daily.	01640			

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01640	Continued From page 34 R4's Service Plan indicated R4 received the following services related to medication management: - medication set up one time per day with a fee for service of \$28.54 per day; - medication administration three times daily and as needed with a fee for service of \$28.81 per day; and - verbal or visual medication reminders three times daily and as needed with a fee for service of \$26.09 per day. On September 23, 2024, at 12:30 p.m., during the facility tour, the surveyor observed the house medication cabinet to include a set up medication box with four rows of boxes labeled for R4 with boxes labeled 8:00 a.m., noon, evening, and 8:00 p.m. The 8:00 a.m. boxes contained medications in five days, the noon boxes were all empty, the evening boxes contained medications in two days, and the 8:00 p.m. boxes were all empty. In addition to the set-up boxes, R4 had one bubble pack card from the pharmacy for weekly medication every Friday. LALD/CNS-A stated they set up medications for R4 weekly but R4 has been refusing all medications due to stomach issues except the weekly medication in the bubble pack. The service recap summary and September 2024 MAR indicated medication administration four times daily at 7:00 a.m., 7:30 a.m., 9:00 a.m., and 9:00 p.m. On September 24, 2024, at 9:14 a.m., the surveyor observed ULP-B verbally offer R4 their scheduled medications. R4 stated no, I don't need any of those medications anymore. On September 25, 2024, at 12:00 p.m.,	01640			

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01640	Continued From page 35 LALD/CNS-A stated there was additional behavior monitoring that staff completed but were not included on the service plan for R3 and R4. LALD/CNS-A stated they were good practice and wanted the monitoring completed but it was not included on the service plan because the payer did not cover the additional monitoring items. R5 R5 was admitted to the licensee and began receiving assisted living services on December 12, 2022. R5's diagnoses included cerebral palsy, major depressive disorder, fibromyalgia, general anxiety disorder, and post-traumatic stress disorder. R5's Service Plan, dated December 12, 2022, was signed by R5 and LALD/CNS-A and indicated R5 received the following services: - housekeeping daily; - home making weekly; - laundry two times weekly and as needed; - shopping weekly and as needed; - assistance making appointments one time monthly and as needed; - home management: arrange non-medical transportation weekly and as needed; - one to one socialization two times daily; - three meals and two snacks daily, - arrange non-medical transportation including driver 1:1 and mileage 1:1 two times weekly; - grooming two times daily and as needed; - bathing two times weekly; - standby assistance with walking daily; - make sure cane is in reach of R5 daily; - assistance with medication administration/ self-administration three times daily and as needed; - verbal or visual medication reminders three	01640			

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01640	Continued From page 36 times daily and as needed; - delegated clinical monitoring for choking without a frequency listed; - delegated clinical monitoring for skin audit without a frequency listed; - delegated clinical monitoring for COVID-19 without a frequency listed; - medication set up and monitoring daily; - daily monitoring and management of orientation issues; - daily monitoring and management of anxiety; - daily monitoring and management of repetitive behavior; - daily monitoring and management of agitation; - daily monitoring and management of verbal aggression; and - daily monitoring and management of verbal aggression, post-traumatic stress disorder (PTSD), and major depressive disorder (MDD). R5's Service Recap Summary, dated September 2024, indicated R5 received the following services that were not included in R5's service plan: - monitor blood pressure daily; - record oxygen saturation percentage daily; - monitor temperature, pulse, and respirations daily; - supervision of wound care weekly by the registered nurse; - wound care daily by ulp; and - meal assistance daily. R5's service plan indicated the following services were provided but were not included on the Service Recap Summary: - bathing twice weekly; - making sure cane is within reach of R5 daily; and - manage repetitive behavior.	01640			

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01640	Continued From page 37 R5's Service Plan also indicated R5 received the following services related to medication management: - medication set up one time per day with a fee for service of \$28.54 per day; - medication administration three times daily and as needed with a fee for service of \$27.04 per day; - verbal or visual medication reminders three times daily and as needed with a fee for service of \$11.86 per day. On September 23, 2024, at 12:30 p.m., during the facility tour, the surveyor observed the house medication cabinet to include bubble pack cards of as needed medications for R5. No other scheduled medications or set up boxes were observed in the medication cabinet. LALD/CNS-A stated they kept R5's medications in their office and they set them up weekly for R5, then R5 self-administered the set-up medications. The Service Recap Summary and September 2024 MAR indicated medication administration five times daily at 7:30 a.m., 10:00 a.m., 11:30 a.m., 4:00 p.m., and 10:00 p.m. In addition to the medication administration times, the Service Recap Summary indicated staff assisted with self-administration of medications and provided verbal medication reminders AM and overnight. On September 25, 2024, at 12:33 p.m., the surveyor observed R5's eye drops, nasal spray, and set up medication box in R5's room. R5 stated LALD/CNS-A set up their medications in the medication box every Monday, then R5 kept the set-up box in their room, and removed medications from the box for self-administration.	01640			

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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
01640	Continued From page 38 On September 25, 2024, at 9:59 a.m., the surveyor observed ULP-B go into R5's room to verbally remind R5 to take their 10:00 a.m. medications. R5 requested additional medications that ULP-B prepared and administered. ULP-B stated they verbally remind R5 of medications around 10:00 a.m., and 4:00 p.m. ULP-B stated they do not provide reminders before 10:00 a.m., because R5 would still be sleeping. ULP-B also stated they do not provide another separate medication reminder at 11:30 a.m. DUPLICATE SERVICE LISTED All three residents had arranged non-medical transportation in two areas on their service plan with fees included in both locations. R3 - home management: arrange non-medical transportation weekly and as needed with a fee for service of \$5.44 per week. - arrange non-medical transportation including driver, 1:1, mileage 1:1, Driver-Riders 3-5, mileage- riders 3-5 two times weekly and as needed with a fee for service of \$20.77 per day. R4 - home management: arrange non-medical transportation weekly and as needed with a fee for service of \$38.05 per day. - arrange non-medical transportation including driver, 1:1, mileage 1:1, Driver 3, Mileage, Driver 3-5 two times weekly with a fee for service of \$44.14 per day. R5 - home management: arrange non-medical transportation weekly and as needed with a fee for service of \$4.46 per day. - arrange non-medical transportation including	01640			

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01640	Continued From page 39 driver, 1:1 (one to one staff support), mileage 1:1 two times weekly with a fee for service of \$17.32 per day. The licensee's undated Service Plan policy indicated assisted living services would be provided according to a suitable and current written service plan. The service plan would be developed with the resident/representative and was based on resident needs and preferences. The service plan and any revisions would include a signature or other authentication by the licensee and by the resident or resident's representative documenting agreement on the services to be provided. Staff providing assisted living services would be informed of services identified in the current written service plan. The service plan would be revised as needed based on resident assessment. The licensee would implement and provide all services required by the current service plan. The resident would be advised, orally and in writing, of any changes in type or frequency of services or fee schedule. The original Service Plan and any revisions would be maintained in the resident record, including notice of a change in fees when applicable. In addition, all changes in the Service Plan would be acknowledged by the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility	01730			

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01730	Continued From page 40 must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.	01730			

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01730	Continued From page 41 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a current individualized medication management plan to include all required content for three of three residents (R3, R4, R5). 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: R3 R3 was admitted to the licensee and began receiving assisted living services on September 16, 2022. R3's diagnoses included Type II Diabetes, major depressive disorder, arteriosclerotic cardiovascular disease, and hypertension. R3's Service Plan, dated July 2, 2024, indicated R3 received medication set up and administration, assistance with transfers, ambulation, bathing, dressing, grooming, housekeeping, laundry, meal preparation, shopping, and socialization. R3's Physician Orders, dated August 26, 2024, included scheduled oral, eye, topical, injectable, and as needed oral, nasal, sublingual, and rectal medications.	01730			

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01730	Continued From page 42 R3's September 2024 Medication Administration Record (MAR) listed medications as prescribed, times to administer, and staff initials through September 24, 2024, to indicate the medications had been given. R3's Individualized Medication Management Plan (IMMP), dated August 30, 2024, indicated facility would manage all medications for R3, all medications were stored in a locked cabinet, medication management tasks that may be delegated to unlicensed personnel (ULP) included topical, and the RN would administer a weekly subcutaneous injection. On September 23, 2024, at 12:33 p.m., the surveyor observed the locked cabinet indicated for medication storage. R3's medication box for the current week that had been set up by the nurse was in the locked medication cabinet. On September 23, 2024, at 12:37 p.m., the surveyor observed R3's injectable medication in storage located in a medication refrigerator in licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A's office. R3's medication cards from the pharmacy used to set up the medication box that had been observed in the medication cabinet were stored in an unsecured paper bag in LALD/CNS-A's locked office. On September 25, 2024, at 8:07 a.m., the surveyor observed ULP-B prepare and administer R3's scheduled oral medications. On September 25, 2024, at 10:46 a.m., ULP-B stated they had applied R3's topical medication to R3's neck and chest in the bathroom earlier that	01730			

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01730	Continued From page 43 morning. R4 R4 was admitted to the licensee and began receiving assisted living services on May 10, 2022. R4's diagnoses included hypothyroidism, major depressive disorder, fetal alcohol spectrum disorder, and seizure disorder. R4's Service Plan, dated April 2, 2024, indicated R4 received medication set up and administration, assistance with bathing, dressing, grooming, housekeeping, laundry, meal preparation, transportation, shopping, socialization, and behavior management. R4's Physician Orders, dated June 25, 2024, included scheduled oral and as needed oral, nasal, topical, and rectal medications. R4's September 2024 MAR listed medications as prescribed, times to administer, and staff initials through September 24, 2024, to indicate the medications had been given or circled initials to indicate medications refused. R4's IMMP, dated August 12, 2024, indicated facility would manage all medications for R4, all medications were stored in a locked cabinet, medication management tasks that may be delegated to ULP included nasal. On September 23, 2024, at 12:33 p.m., the surveyor observed the locked cabinet indicated for medication storage. R4's medication box for the current week that had been set up by the nurse was in the locked medication cabinet.	01730			

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01730	Continued From page 44 On September 23, 2024, at 12:37 p.m., the surveyor observed R4's medication cards from the pharmacy used to set up the medication box that had been observed in the medication cabinet were stored in an unsecured paper bag in LALD/CNS-A's locked office. On September 25, 2024, at 9:14 a.m., ULP-B asked R4 if they would take their scheduled morning medications. R4 stated, "no, I don't need any of those meds anymore". R5 R5 was admitted to the licensee and began receiving assisted living services on December 12, 2022. R5's diagnoses included cerebral palsy, major depressive disorder, fibromyalgia, general anxiety disorder, and post-traumatic stress disorder. R5's Service Plan, dated December 12, 2022, indicated R5 received medication set up, administration, and reminders, assistance with transfers, bathing, grooming, housekeeping, laundry, meal preparation, shopping, transportation, and socialization. R5's Physician Orders, dated August 6, 2024, included scheduled oral and eye medications, and as needed oral, nasal, and topical medications. R5's September 2024 MAR listed medications as prescribed, times to administer, and staff initials through September 24, 2024, to indicate the medications had been given. R5's IMMP, dated August 12, 2024, indicated R5 was able to self-administer medications after they	01730			

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01730	Continued From page 45 had been set up by the nurse, the facility would store and dispense all controlled medications, the nurse set up medications for R5 and then handed R5 the medication box, that all medications were stored in a locked cabinet, ULP provided medication reminders, and medication management tasks that may be delegated ULP included topical. On September 23, 2024, at 12:33 p.m., the surveyor observed the locked cabinet indicated for medication storage. There was a shelf labeled for R5 that did not contain any medications. LALD/CNS-A stated R5 kept their medication box in their room. On September 23, 2024, at 12:37 p.m., the surveyor observed R5's medication cards from the pharmacy stored in an unsecured paper bag in LALD/CNS-A's locked office. On September 25, 2024, at 9:56 a.m., the surveyor observed ULP-B prepare and administer as needed controlled substances requested by R5. ULP-B reminded R5 to take their scheduled morning medications. R5 confirmed they had already taken them. On September 25, 2024, at 12:33 p.m., the surveyor observed R5's medication box that had been set up by the nurse, eye drops, nasal spray, and oral contraceptive pill pack in R5's room. R5 demonstrated taking medications out of the set-up box for 4:00 p.m., bedtime, and 10:00 a.m., the next morning and putting them into stacked plastic cups on their nightstand so they were ready for the rest of the day and next morning. R3, R4, and R5's records lacked a medication	01730			

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01730	Continued From page 46 management plan to include: - a description of medication storage system, based on the resident's needs to include all medications the resident was currently prescribed and that were kept onsite at the facility; and - identification of all medication management tasks that may be delegated to unlicensed personnel for each resident. On September 25, 2024, at 3:00 p.m., LALD/CNS-A verified the individual medication management plans for all residents did not describe storage procedures for refrigerated medications or the medications not yet set up in the locked medication cabinet. LALD/CNS-A stated the ULPs were able to administer medications via all routes for the residents in the facility and should be identified on the plan. The licensee's undated Individualized Medication Management Plan and Record policy indicated the licensee would develop and maintain a current individualized medication management plan for each resident. The plan would include: - a description of how medications would be stored, based on the resident's needs, risk of diversion and consistent with the manufacturer's directions; and - identification of medication management tasks that may be delegated to unlicensed personnel. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all	01880			

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01880	Continued From page 47 prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to store all medications according to manufacturer's instructions when they failed to monitor the medication refrigerator temperature. This had the potential to affect all residents with refrigerated medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 23, 2024, at 12:37 p.m., the surveyor observed the medication storage refrigerator in licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A's office. The medication refrigerator lacked the presence of a thermometer. No temperature log was observed to be on or near the medication refrigerator. The medication refrigerator contained one box of Byderion BCise 2 mg extended-release single-dose autoinjectors prescribed to R3. The manufacturer's instructions on the box indicated the medication should be stored in refrigerator between thirty-six- and forty-six-degrees	01880			

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01880	Continued From page 48 Fahrenheit. On September 23, 2024, at 12:37 p.m., when asked about a method of checking the temperature of the medication refrigerator and a record of the temperature history, LALD/CNS-A stated they had not been checking the temperature of the refrigerator. The licensee's undated Medication Prescriptions and Refills policy indicated the registered nurse would verify delivery of medications and supplies, which would then be placed into the secured medication storage area. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to discard expired medication for one of three residents (R5). 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	01890			

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01890	Continued From page 49 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: R5 was admitted to the licensee and began receiving assisted living services on December 12, 2022. R5's diagnoses included cerebral palsy, major depressive disorder, fibromyalgia, general anxiety disorder, and post-traumatic stress disorder. R5's Service Plan, dated December 12, 2022, indicated R5 received medication set up, administration, and reminders, assistance with transfers, bathing, grooming, housekeeping, laundry, meal preparation, shopping, transportation, and socialization. On September 23, 2024, at 12:33 p.m., during a facility tour, the surveyor a observed a basket with varied supplies and expired medications in the facility medication closet located on the main level of the facility. Employees accessed the medication closet multiple times each day. The basket contained the following expired medications prescribed to R5: - neomycin polymyxin B sulfates hydrocortisone 1 % otic solution one vial that expired February 2023; - triamcinolone acetonide cream usp 0.5% two tubes that expired June 2024; - triamcinolone acetonide ointment usp 0.1% three tubes that expired June 2024; - bacitracin first aid antibiotic ointment three tubes	01890			

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01890	Continued From page 50 that expired on November 7, 2023; - azelastine 137 microgram (mcg) per spray 0.1% nasal solution that expired on April 4, 2023; and - one individual dose pack set up by pharmacy for administration in the morning on October 22, 2023, that expired on September 24, 2024. The dose pack included two tablets of baclofen 20 mg, one tablet of cetirizine 10 mg, one daily multivitamin tablet, one tablet desveniafaxine extended release (ER) 100 mg, one tablet lamotrigine 100 mg, one tablet metoprolol succinate 25 mg, and one tablet promethazine 25 mg. On September 23, 2024, at 12:38 p.m., during a facility tour, the surveyor observed a paper bag on top of a file cabinet locked in licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A's office. LALD/CNS-A stated they try to go through the medication cabinet at least quarterly to remove anything not in use. LALD/CNS-A stated their practice was to remove those items from the medication cabinet and keep them in their office until they could be destroyed. LALD/CNS-A stated they bring expired and discontinued medications to a facility in Maple Grove for destruction, but they wait until there is a large amount and bring them all at once to be worth the trip. The licensee's undated Medication Disposition or Disposal policy indicated all medications managed and secured by the facility that were left after the prescription medication was discontinued, would be destroyed by the nurse or pharmacist with one other person as a witness. The policy specified that discontinued or unused medications would be destroyed within one month or less of the time they were discontinued. In addition, staff would document the disposition or	01890			

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01890	Continued From page 51 disposal of medications in the resident record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
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 observation, interview, and record review, the licensee failed to dispose of medications remaining with the facility that were expired upon termination of the service contract for one of one resident (R1).	01910			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35670	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2024
NAME OF PROVIDER OR SUPPLIER GLOBAL ALLIANCE HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 4833 WINNETKA AVENUE NORTH CRYSTAL, MN 55428			
(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
01910	Continued From page 52 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: On September 23, 2024, at 12:21 p.m., when reviewing the current resident medication storage area with licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A, the surveyor observed a medication in the facility medication storage area that was prescribed to R1. R1 was admitted to the licensee and began receiving assisted living services on February 5, 2021, and was discharged from facility on December 29, 2023. R1's diagnoses included schizophrenia, depression, anxiety, and substance use disorder. R1's clobetasol 0.05 percent (%) ointment was in the facility medication storage on September 9, 2024. The medication was on a shelf in the medication cabinet labeled with R1's name. On September 25, 2024, at 11:20. a.m., LALD/CNS-A stated they had not realized the clobetasol ointment was still on the shelf in the medication cabinet. LALD/CNS-A stated they would have removed all of R1's medications from the cabinet upon discharge but must not have seen the clobetasol ointment. LALD/CNS-A stated it must have been too far back or	01910			

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01910	Continued From page 53 something, but they did not see it and were not aware it was still in the cabinet. The licensee's undated Medication Disposition or Disposal policy indicated all medications managed and secured by the facility that were left after the death or termination of services for a resident for whom the medication was prescribed, or any prescription medication permanently discontinued, must be destroyed by the nurse or pharmacist with one other person as a witness. The policy specified that discontinued or unused medications would be destroyed within one month or less of the time they are discontinued or the day of death or discharge of the resident. In addition, staff would document the disposition or disposal of medications in the resident record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			

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Location:

Global Alliance Home Health
4833 Winnetka Avenue North
Crystal, MN 55428
Hennepin County, 27

Establishment Info:

ID #: 0037452
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6124539211
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.

7-200 Toxic Supplies and Applications

7-204.11 **** Priority 1 ****

MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.

THE CHLORINE ON-SITE WAS LEMON SCENTED AND IT IS NOT INTENDED FOR FOOD CONTACT SURFACES. STAFF WILL GET APPROVED BLEACH TO USE IN THE KITCHEN. FACT SHEET WITH APPROVED FOOD CONTACT SANITIZERS SENT WITH REPORT.

Comply By: 09/24/24

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.

OPEN GALLON OF MILK AND OPEN BAG OF DELI MEAT FOUND IN THE KITCHEN REFRIGERATOR WITHOUT A DATE MARK. DISCUSSED DATE MARKING WITH STAFF AND THEY WILL DATE MARK TCS FOOD ITEMS.

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6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

HANDWASHING SINK IN THE EMPLOYEE BATHROOM IS MISSING A HANDWASHING SIGN/POSTER THAT REMINDS FOOD EMPLOYEES TO WASH HANDS BEFORE RETURNING TO WORK. PROVIDE AS DESCRIBED IN RULE ABOVE.

Comply By: 09/26/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

THE LAMINATE COUNTERTOP NEXT TO THE STOVE HAS SOME DAMAGE IN THE FORM OF HOLES. REPAIR OR REPLACE THE LAMINATE COUNTERTOP.

Comply By: 10/08/24

Food and Equipment Temperatures

Process/Item: Cold Holding

Temperature: 40 Degrees Fahrenheit - Location: MILK - FRIGIDAIRE REFRIGERATOR

Violation Issued: No

Process/Item: Cold Holding

Temperature: 39 Degrees Fahrenheit - Location: SLICED HAM - FRIGIDAIRE REFRIGERATOR

Violation Issued: No

Process/Item: Ambient Temperature

Temperature: 39 Degrees Fahrenheit - Location: FRIGIDAIRE REFRIGERATOR

Violation Issued: No

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

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH RN/LALD, KING DICKSON, AND HEALTH REGULATION DIVISION NURSE EVALUATOR, PEGGY ANDERSON.

THIS FACILITY IS A RESIDENTIAL HOME AND THEY CURRENTLY HAVE 3 CLIENTS AND THE FACILITY CAN HAVE UP TO 6 CLIENTS.

PER CONVERSATION WITH KING, FOOD IS MADE FOR SAME DAY SERVICE. NO LEFTOVERS ARE KEPT.

THE KITCHEN HAS RESIDENTIAL EQUIPMENT, LAMINATE COUNTERS, VINYL FLOORS, AND PAINTED DRYWALL. PHYSICAL FACILITY ITEMS WILL BE MONITORED DURING FUTURE INSPECTIONS.

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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 1021241284 of 09/24/24.

Certified Food Protection Manager MICHAEL J. HUNTER

Certification Number: FM118114 Expires: 07/15/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

KING DICKSON
RN/LALD

Signed:  _____

Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us