



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

October 27, 2023

Licensee  
Aliya Care Inc  
12460 Sycamore Street Northwest  
Coon Rapids, MN 55448

RE: Project Number(s) SL34412015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 17, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

#### **STATE CORRECTION ORDERS**

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

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

#### **DOCUMENTATION OF ACTION TO COMPLY**

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

The correction order documentation should include the following:

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

**CORRECTION ORDER RECONSIDERATION PROCESS**

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

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

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

Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in cursive script that reads "Jessie Chenze".

Jessie Chenze, Supervisor  
State Evaluation Team  
Email: jessie.chenze@state.mn.us  
Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>34412</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | (X3) DATE SURVEY COMPLETED<br><br><b>10/17/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ALIYA CARE INC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>12460 SYCAMORE STREET NW<br/>COON RAPIDS, MN 55448</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                     |
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| 0 000                                                     | <p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING<br/>CORRECTION ORDER(S)</p> <p>In accordance with Minnesota Statutes, section<br/>144G.08 to 144G.95, these correction orders are<br/>issued pursuant to a survey.</p> <p>Determination of whether violations are corrected<br/>requires compliance with all requirements<br/>provided at the Statute number indicated below.<br/>When Minnesota Statute contains several items,<br/>failure to comply with any of the items will be<br/>considered lack of compliance.</p> <p>INITIAL COMMENTS:<br/>SL34412015</p> <p>On October 16, 2023, through October 17, 2023,<br/>the Minnesota Department of Health conducted a<br/>survey at the above provider, and the following<br/>correction orders are issued. At the time of the<br/>survey, there were two active residents all whom<br/>were receiving services under the Assisted Living<br/>license.</p> | 0 000                                                                  | <p>Minnesota Department of Health is<br/>documenting the State Correction Orders<br/>using federal software. Tag numbers have<br/>been assigned to Minnesota State<br/>Statutes for Assisted Living License<br/>Providers. The assigned tag number<br/>appears in the far left column entitled "ID<br/>Prefix Tag." The state Statute number and<br/>the corresponding text of the state Statute<br/>out of compliance is listed in the<br/>"Summary Statement of Deficiencies"<br/>column. This column also includes the<br/>findings which are in violation of the state<br/>requirement after the statement, "This<br/>Minnesota requirement is not met as<br/>evidenced by." Following the surveyors'<br/>findings is the Time Period for Correction.</p> <p>PLEASE DISREGARD THE HEADING OF<br/>THE FOURTH COLUMN WHICH<br/>STATES,"PROVIDER'S PLAN OF<br/>CORRECTION." THIS APPLIES TO<br/>FEDERAL DEFICIENCIES ONLY. THIS<br/>WILL APPEAR ON EACH PAGE.</p> <p>THERE IS NO REQUIREMENT TO<br/>SUBMIT A PLAN OF CORRECTION FOR<br/>VIOLATIONS OF MINNESOTA STATE<br/>STATUTES.</p> <p>The letter in the left column is used for<br/>tracking purposes and reflects the scope<br/>and level issued pursuant to 144G.31<br/>subd. 1, 2, and 3.</p> |  |                                                     |
| 0 470<br>SS=F                                             | <p>144G.41 Subdivision 1 Minimum requirements</p> <p>(11) develop and implement a staffing plan for<br/>determining its staffing level that:</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 0 470                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                     |

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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

Minnesota Department of Health

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| 0 470                                                     | <p>Continued From page 2</p> <p>or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>The licensee held an assisted living license. The facility was licensed for a capacity of five and had a current census of two residents.</p> <p>During the entrance conference on October 16, 2023, at 12:32 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the usual staffing schedule for the facility was as follows:</p> <ul style="list-style-type: none"><li>- LALD/CNS-A was on site approximately 30 hours a week</li><li>- one unlicensed personnel (ULP) was scheduled 24/7</li></ul> <p>On October 17, 2023, at 7:18 a.m., LALD/CNS-A provided an October calendar with one ULP scheduled 24/7. LALD/CNS-A stated this was all she had, and she was unaware a written staffing plan needed to be developed and reviewed twice a year.</p> <p>The licensee's Staffing policy dated August 1, 2021, indicated the CNS would prepare and implement a 24-hour daily staffing plan that ensures adequate staffing to meet residents' needs at all times, including reasonably foreseeable needs. The staffing plan is based on an evaluation of the appropriateness of the staffing levels in the facility and is reviewed at least twice a year.</p> <p>Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0180, Subpart 4, item B., electronically posted October 11, 2022, the daily</p> | 0 470                                                                  |                                                                                                                          |  |                                                     |

Minnesota Department of Health

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| 0 470                                                     | Continued From page 3<br><br>work schedule in item A must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. The facility shall not disclose any information that is protected by law from public disclosure.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-One (21) days                                                                                                                                                                                                                                                                                                                                                                                                                         | 0 470                                                                                              |                                                                                                                          |  |                                                        |
| 0 480<br>SS=F                                             | 144G.41 Subd 1 (13) (i) (B) Minimum requirements<br><br>(13) offer to provide or make available at least the following services to residents:<br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br>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).<br>The findings include:<br>Please refer to the document titled, Food and | 0 480                                                                                              |                                                                                                                          |  |                                                        |

Minnesota Department of Health

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| 0 480                                                     | Continued From page 4<br><br>Beverage Establishment Inspection Report (FBEIR) dated October 17, 2023, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.<br>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 0 480                                                                  |                                                                                                                          |  |                                                     |
| 0 550<br>SS=F                                             | <b>144G.41 Subd. 7 Resident grievances; reporting maltreatment</b><br><br>All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to post the required information related to the grievance procedure; contact information for the regional Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities; as well as information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC) as required. | 0 550                                                                  |                                                                                                                          |  |                                                     |

Minnesota Department of Health

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| 0 550                                                     | <p>Continued From page 5</p> <p>This had the potential to affect all current residents, staff, and visitors.</p> <p>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).</p> <p>The findings include:</p> <p>On October 16, 2023, at 1:20 p.m., the surveyor completed the facility tour with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. The surveyor did not observe the following information posted:</p> <ul style="list-style-type: none"><li>- the facility's grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances;</li><li>- contact information for the Office of Ombudsman for Long-Term Care and Office of Ombudsman for Mental Health and Developmental Disabilities;</li><li>- information for reporting suspected maltreatment to the MAARC; and</li><li>- a notice that states if an individual has a complaint about the facility or persons providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health.</li></ul> <p>On October 16, 2023, at 1:31 p.m., LALD/CNS-A stated she had thought the above information had been posted and it may have been misplaced.</p> <p>The licensee's Grievance policy dated August 1,</p> | 0 550                                                                  |                                                                                                                          |  |                                                     |

Minnesota Department of Health

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>ALIYA CARE INC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>12460 SYCAMORE STREET NW<br/>COON RAPIDS, MN 55448</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                                                | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 550                                                     | Continued From page 6<br><br>2021, noted a copy of the grievance procedure would be conspicuously posted in the residence with the following information:<br>- Name, phone number and email contact information for the individuals who are responsible for handling resident complaints<br>- Contact information for the state and any regional Office of Ombudsman for Long-Term Care<br>- Contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities<br>- Contact information for the MAARC<br><br>No further information was provided.<br><br>TIME PERIOD OF CORRECTION: Twenty-One (21) days                                                                                                                                | 0 550                                                                                              |                                                                                                                          |  |                                                        |
| 0 640<br>SS=F                                             | 144G.42 Subd. 7 Posting information for reporting suspected c<br><br>The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by:<br>(1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility;<br>(2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and<br>(3) providing reasonable accommodations with information and notices in plain language.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee | 0 640                                                                                              |                                                                                                                          |  |                                                        |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>ALIYA CARE INC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>12460 SYCAMORE STREET NW<br/>COON RAPIDS, MN 55448</b> |                                                                                                                          |                                                        |
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| 0 640                                                     | <p>Continued From page 7</p> <p>failed to post required content to include the 911 emergency number in common areas. This had the potential to affect all two residents, staff, and visitors.</p> <p>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).</p> <p>The findings include:</p> <p>On October 16, 2023, at 1:26 p.m., the surveyor toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. The surveyor did not observe the 911 emergency number posted in common areas or near the cordless phone in the office. LALD/CNS-A stated the cordless phone in the office can be used by staff, residents, or visitors. LALD/CNS-A stated the 911 emergency number was not posted near the cordless phone and/or in common areas.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION:<br/>Twenty-One (21) days</p> | 0 640                                                                                              |                                                                                                                          |                                                        |
| 0 680<br>SS=F                                             | <p>144G.42 Subd. 10 Disaster planning and emergency preparedness</p> <p>(a) The facility must meet the following requirements:<br/>(1) have a written emergency disaster plan that contains a plan for evacuation, addresses</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 0 680                                                                                              |                                                                                                                          |                                                        |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>ALIYA CARE INC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>12460 SYCAMORE STREET NW<br/>COON RAPIDS, MN 55448</b>                       |  |                                                     |
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| 0 680                                                     | <p>Continued From page 8</p> <p>elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;</p> <p>(2) post an emergency disaster plan prominently;</p> <p>(3) provide building emergency exit diagrams to all residents;</p> <p>(4) post emergency exit diagrams on each floor; and</p> <p>(5) have a written policy and procedure regarding missing residents.</p> <p>(b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.</p> <p>(c) The facility must meet any additional requirements adopted in rule.</p> <p>This MN Requirement is not met as evidenced by:</p> <p>Based on interview and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, staff, and visitors of the facility.</p> <p>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).</p> <p>The findings include:</p> | 0 680                                                                  |                                                                                                                          |  |                                                     |





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| 0 680                                                     | Continued From page 11<br><br>document any changes to the plan.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-One (21) days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 0 680                                                                     |                                                                                                                          |  |                                                        |
| 0 790<br>SS=E                                             | <b>144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment</b><br><br>(2) install and maintain portable fire extinguishers in accordance with the State Fire Code;<br><br>(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<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be | 0 790                                                                     |                                                                                                                          |  |                                                        |

























































