Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL344129642M
Compliance #: HL344128982C

Date Concluded: April 18, 2025

Name, Address, and County of Licensee Investigated:
Aliya Care
12460 Sycamore St NW
Coon Rapids, MN 55448
Anoka County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lori Pokela
Special Investigator

Finding: Not Substantiated

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

Initial Investigation Allegation(s):
The facility abused the resident by threatening eviction, stealing personal property, monitoring communication, not allowing access to the facility mailbox and paying the resident for providing cares to other residents. In addition, the resident's plan of care was not followed by not allowing access to recommended foods and medication administration.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. During an interview, the resident indicated that the concerns related to the allegations did not occur and/or had been resolved. The resident had no concerns with the care provided by the facility.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's case manager. The investigation included review of the resident record(s), death record, facility incident reports, personnel files, staff schedules, law enforcement reports, and related facility policy and

procedures. Also, the investigator observed the facility's physical plant and staff interactions with the resident.

The resident resided in an assisted living facility. The resident's diagnoses included diabetes mellitus, degenerative joint disease, and bipolar disorder. The resident's service plan included assistance with bathing, dressing, occasionally toileting, stand-by assistance with transfers, meal preparation, behavior monitoring, and medication management. The resident's assessment indicated the resident was alert and oriented to person, place, and time. The assessment indicated the resident required assistance with dressing, toileting, stand-by assistance with walking in the morning, occasionally used a cane or walker for mobility due to pain, and staff assistance to set-up medications.

Documentation indicated that the resident reported she was the only resident living at the facility at the time the alleged incidents occurred. Documentation indicated the resident was threatened by staff to be evicted because she did not pay rent, staff stole the resident's coat, did not offer the resident foods specific to her diagnoses, did not want to her to speak in front of the facility's electronic surveillance cameras, encouraged the resident to lie, provided no access to the facility mailbox, and did not communicate with the resident's case manager. Additionally, there was an allegation that the resident was paid by the facility to provide cares to other residents.

Two separate law enforcement reports, completed within forty-eight hours of each other, indicated the resident was being loud and disruptive. Both staff and the resident called 911. Staff wanted the resident removed from the facility and police informed them they would need to go through the proper process for evicting the resident. The police reports indicated the resident felt harassed but agreed to go to her room to communicate with her case manager about finding a new residence.

Documentation indicated that the facility's administrative staff communicated with the resident's case manager about the law enforcement contact and that the resident had displayed physical aggression, was not taking her antipsychotic medication, and was packing up her belongings with a plan to live with a family member. Administration indicated that the resident was not being evicted and was welcome to stay until she could find another place of residence.

Facility documentation also indicated that a total of three residents resided at the facility. The resident's medical records indicated the resident received antipsychotic medications as prescribed and all meals per her service plan. The investigator observed food in the facility's cupboards, freezer, and refrigerator and a food menu was posted in the entrance along with a facility grievance policy and grievance forms. Observations supported that all facility residents could access the mail out of a shared mailbox.

During an interview, the resident stated she owned her own cell phone and did not have any issues regarding rent payment or being given an eviction notice. The resident stated she had no concerns with missing personal property and facility staff always ensured the resident was stocked with her choice of hygiene supplies. The resident stated the facility had worked with her to take her shopping for groceries and she was able to buy foods she liked and recommended. The resident stated she had never received payment for providing care to other residents. The resident stated communication between the facility staff and her case manager was okay and she felt safe and loved in a family-like atmosphere at the facility.

During interview, the resident's case manager stated she followed up with the resident regarding the incidents reported at the facility and the resident informed the case manager that she did not want to move-out of the facility because everything was going great.

In conclusion, the Minnesota Department of Health determined abuse was not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening.

Vulnerable Adult interviewed: Yes Declined to have a recorded interview.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
None.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34412	A. BUILDING: _____ B. WING _____	C 03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALIYA CARE INC	12460 SYCAMORE STREET NW COON RAPIDS, MN 55448

(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 On March 19, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL344128982C/HL344129642M. No correction orders are issued.	0 000		