



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 15, 2022

Administrator
Aliya Care Inc
2700 37th Avenue Northeast
St Anthony, MN 55421

RE: Project Number(s) SL35486015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on October 21, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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 enclosed State Form documents the state licensing orders. The Department of Health 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 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.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes 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. The Department of Health 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 (a)(5)(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, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing 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 general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general 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

Free from Maltreatment reconsideration requests should be addressed 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 this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

A handwritten signature in dark ink, appearing to read "Jonathan Hill", is positioned above the typed name.

Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-215-9697

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35486	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/21/2022
NAME OF PROVIDER OR SUPPLIER ALIYA CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2700 37TH AVENUE NE ST ANTHONY, MN 55421		
(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 Initial comments *****ATTENTION***** ASSISTED LIVING 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: SL35486015 On October 17, 2022, through October 19, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were no residents receiving services under the provider's Assisted Living license.	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 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.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was not listed as the Director of Record for the licensee. This had the potential to affect all the licensee's 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 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 October 17, 2022, at 1:30 p.m. registered nurse (RN)-A identified as LALD. On October 17, 2022, at 1:30 p.m. the Board of Executives for Long-Term Services and Support (BELTSS) website, indicated RN-A held a current LALD license. The BELTSS website did not indicate LALD was listed as the Director of Record for the licensee. On October 18, 2022, at 12:00 p.m. RN-A verified they were not listed as the Director of Record for licensee and would contact BELTSS	0 110		

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0 110	Continued From page 2 for correction. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This practice resulted in a level two violation (a violation that did not harm a client's health or	0 460		

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0 460	Continued From page 3 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on On October 17, 2022, at 12:30 p.m. registered nurse (RN)-A stated the facility did not have a call system in place for residents On October 18, 2022, at 12:45 p.m. RN--A confirmed the licensee lacked a system for residents to request assistance for health and safety needs 24 hours a day, seven days a week. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 460		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply:	0 480		

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0 480	Continued From page 4 (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 included document titled, Food and Beverage Establishment Inspection Report dated October 19,2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each	0 630		

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0 630	Continued From page 5 vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan was developed to include statements of the specific measures to be taken to minimize the risk of abuse for one of one residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 admitted to facility July 15, 2020, with diagnoses including Mental Health. R1's record included Vulnerability Assessment - individual abuse prevention plan (IAPP) dated July 15, 2020, indicated R1 had vulnerabilities to include not all inclusive: risk for abusing others, susceptible to abuse by others. R1's IAPP lacked statements of the specific measures to be taken	0 630		

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0 630	Continued From page 6 to minimize the risk of abuse to R1 and other vulnerable adults. On October 18, 2022, at 2:15 p.m., registered nurse (RN)-A verified R1's IAPP lacked statements of the specific measures to be taken to minimize the risk of abuse to R1 and other vulnerable adults. RN-A stated licensee was in the process of updating R1's IAPP. No further information was provided TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually	0 680		

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0 680	Continued From page 7 available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have a written emergency preparedness plan with all the required content as defined in Appendix Z. This had the potential to affect the licensee's residents, staff, and guests. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the facility tour on October 17, 2022, at 12:45 p.m. no emergency disaster plan or emergency exit diagrams were observed. On October 17, 2022, at 1:30 p.m., the surveyor requested to review the licensee's emergency preparedness plan (EP), and a three ringed binder was provided. The licensee's EP lacked the following: - EP posted emergency disaster plan prominently; - provide building emergency exit diagrams to all	0 680		

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0 680	Continued From page 8 residents; - post emergency exit diagrams on each floor; - Maintain and annual EP updates; - EP program patient population; - Process for EP collaboration; - Subsistence needs for staff and patients; - Roles under a waiver declared by Secretary; - Development of communication plan; - Emergency officials contact information; - Primary/alternate means for communication; - Methods for sharing information; - Sharing information on occupancy/needs; - Emergency prep training and testing; - Emergency prep training program; and - Emergency prep testing requirements; On October 18, 2022, at 2:30 p.m. registered nurse (RN)-A stated the licensee's EP lacked the content above. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated, "Aliya Care will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services." The policy further indicated, "The Emergency Disaster Plan is prominently posted on each floor of the facility and includes: a. A schematic plan of the facility or portions of the facility that shows i. Evacuation routes ii. As applicable, smoke stop and fire doors iii. Emergency exit diagrams No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 780	Continued From page 9	0 780		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure smoke alarms are interconnected so that actuation of one alarm causes all alarms in the dwelling to actuate as required. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 780		

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0 780	Continued From page 10 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 residents). The findings include: On October 18, 2022, between 10:30 a.m. and 12:00 p.m., survey staff toured the facility with the registered nurse (RN)-A. During the facility tour, survey staff observed the smoke alarms were not interconnected when tested. RN-A verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
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	0 790		

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0 790	Continued From page 11 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure installation and maintenance of the correctly sized portable fire extinguishers at the facility. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 residents). The findings include: On October 18, 2022, between 10:30 a.m. and 12:00 p.m., survey staff toured the facility with the registered nurse (RN)-A. During the facility tour, survey staff observed the installed fire extinguishers were not the size required by statute. RN-A verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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,	0 800		

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER ALIYA CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2700 37TH AVENUE NE ST ANTHONY, MN 55421		
(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
0 800	Continued From page 12 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 facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 residents). The findings include: On October 18, 2022, between 10:30 a.m. and 12:00 p.m., survey staff toured the facility with registered nurse (RN)-A. During the facility tour, survey staff observed the following: 2702 Unit 1. Bedroom #2 had no window screen. 2. The exhaust fan in the bathroom was covered in lint and dust. 3. The laundry room in the basement had signs of water penetration. There was black staining and what appeared to be mold or moss growing along the mortar joints of the concrete block foundation wall.	0 800		

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0 800	Continued From page 13 2700 Unit 1. The window well in basement bedroom #1 had plants and vines growing in it. The plants made the egress window difficult to open at the time of the survey. 2. Basement bedroom #1 also had a broken light in the closet and no cover plate on the light switch. 3. The window well in basement bedroom #2 was obstructed by a large bush. The bush was part of the landscaping for the building and had grown large enough to cover the egress window well almost completely. 4. Upstairs bedrooms #1 and #2 had broken closet doors. The closet doors were the mirror type of door and each mirror was cracked in one or more places. RN-A verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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: (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	0 810		

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0 810	Continued From page 14 (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 interview and record review, the licensee failed to develop and maintain fire safety and evacuation plans, failed to provide required training to residents and employees for fire safety and evacuation, and failed to conduct required employee evacuation drills. This had the potential to affect all current residents, staff, and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 810		

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0 810	Continued From page 15 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 residents). The findings include: On October 18, 2022, between 10:30 a.m. and 12:00 p.m., survey staff toured the facility with registered nurse (RN)-A. During the facility tour, survey staff observed no posted evacuation plans in the building. RN-A verbally confirmed survey staff observations during the facility tour. During interview on October 18, 2022, at 12:15 p.m., RN-A stated they had not done any resident training, staff training, or evacuation drills due to frequent overturn of residents and staff. Review of the fire safety policy showed the following: 1. No evacuation plan or documentation on specific procedures for the residents including procedures for their movements, and relocation during a fire or similar emergency. No written instructions for addressing any unique situation during an evacuation, especially for residents who need assistance during an evacuation. 2. No record of required employee evacuation drills. 3. No schedule or records on the training of employees on fire safety and evacuation; on proper actions to take in the event of a fire or emergency for the safety of residents including movement, evacuation, or relocation. There was no language in the policy regarding staff training.	0 810		

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0 810	Continued From page 16 4. No schedule or records on the training of residents who are capable of assisting in their evacuation; on proper actions to take in the event of a fire or emergency for their safety including movement, evacuation, or relocation. There was no language in the policy regarding resident training. 5. No fire safety and evacuation plan that showed the location and number of resident rooms. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of	01470		

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01470	Continued From page 17 complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to include all required content for one	01470		

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01470	Continued From page 18 of one unlicensed personnel (ULP)-B. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: ULP-B had a hire date of July 23, 2019, ULP-B's employee record lacked documentation of required training. ULP-B's employee record lacked evidence to indicate the employee had received orientation to include the following topics: - an overview of Assisted Living laws 144G. - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person - handling of emergencies and use of emergency services - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of	01470		

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01470	Continued From page 19 Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services the employee would be providing and the facility's category of licensure. On October 18, 2022, at 1:38 p.m., registered nurse (RN)-A verified ULP-B's record lacked orientation to assisted living licensing requirements and regulations noted above. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated training would include an "overview of Minnesota Assisted Living Statute 144G and Minnesota Rules Chapter 4659," and the "principles of person-centered planning and service delivery and how they apply to direct support services provided by staff." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of	01500		

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01500	Continued From page 20 vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased	01500		

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01500	Continued From page 21 incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment for one of one employees (unlicensed personnel (ULP-B) with employee records reviewed. 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: ULP-B had a hire date of July 23, 2019, ULP-B's employee records lacked evidence of eight hours of annual training. ULP-B's employee training records lacked evidence ULP-B had successfully completed annual training as required in the following areas: -training on reporting of maltreatment of vulnerable adults under section 626.557; -review of the assisted living bill of rights and staff	01500		

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01500	Continued From page 22 responsibilities related to ensuring the exercise and protection of those rights; -review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; -effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On October 18, 2022, at 1:00 p.m., registered nurse (RN)-A stated all staff have completed required annual training through the online program Educare, but RN-A confirmed employee record lacked evidence the topics noted above. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated, "All staff that providing [sic] assisted living services will complete at least eight (8) hours of education for every 12 months of employment." . No further information was provided. TIME PERIOD FOR CORRECTION:	01500		

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01500	Continued From page 23 Twenty-One (21) days	01500		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee lacked documentation of disposition of medication for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	01910		

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01910	Continued From page 24 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 admitted to facility July 15, 2020, and discharged on September 23, 2022. R1 record included Discharge Summary dated September 23, 2022, indicated "client took her meds [medications]." R1's record lacked evidence of documentation to include 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. On October 18, 2022, at 2:15 p.m., registered nurse (RN)-A stated medications were given to the resident by staff, but no documentation was completed. RN-A confirmed R1's record lacked documentation of disposition of medication. The licensee's Disposition and Disposal of Medications dated August 01, 2021 indicated "Upon disposition, Aliya Care will document the following information in the clinical record a. Name, strength, and prescription number of medication, as applicable b. Quantity c. Method of disposition or to whom the medications were given d. Date of disposition e. Name(s)/signature(s) of staff or other individuals involved in disposition f. If applicable, to whom the medications were given."	01910		

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01910	Continued From page 25 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			

Type: Full
Date: 10/19/22
Time: 13:43:25
Report: 1023221189

Food and Beverage Establishment Inspection Report

Page 1

Location:

Aliya Care Inc
2700 37th Avenue Ne
St Anthony, MN55421
Hennepin County, 27

Establishment Info:

ID #: 0038621
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6124372618
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.

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

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

HIGH TEMP DISH MACHINE IN USE BUT OPERATOR STATED NO WAY TO VERIFY SANITIZATION TEMPERATURE IS REACHED. ACQUIRE AND USE THIS DEVICE.

Comply By: 10/19/22

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
NO CFPM EMPLOYED AT THIS LOCATION BUT STAFF HAS FOOD SAFETY CERTIFICATE.
INCLUDED INFORMATION ON MDH CERTIFICATE TO OPERATOR.

Comply By: 10/19/22

4-200 Equipment Design and Construction

4-204.11

MN Rule 4626.0565 Prevent grease or condensation from exhaust ventilation hood systems from draining or dripping onto food, equipment, utensils, linens, single-service articles, and single-use articles.

REMOVE AND CLEAN HOOD BAFFLES AND GREASE CATCH BASIN TO PREVENT DRIPPING ON TO FOOD AND OTHER EQUIPMENT.

Comply By: 10/19/22

Surface and Equipment Sanitizers

Type: Full
Date: 10/19/22
Time: 13:43:25
Report: 1023221189
Aliya Care Inc

Food and Beverage Establishment Inspection Report

Page 2

Hot Water: = at Degrees Fahrenheit
Location: NSF/ANSI 184
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK
Temperature: 41 Degrees Fahrenheit - Location: REACH IN FRIDGE #1
Violation Issued: No

Process/Item: Cold Hold/JUICE
Temperature: 41 Degrees Fahrenheit - Location: REACH IN FRIDGE #2
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR FROM HRD WAS SAFIA HASSIN. INSPECTION CONDUCTED IN PRESENCE OF THE PERSON IN CHARGE. ALL VIOLATIONS WERE DISCUSSED WITH PERSON IN CHARGE AND HRD EVALUATOR DURING INSPECTION.

THIS FACILITY CONSISTS OF A DUPLEX WITH SIMILAR KITCHENS IN EACH UNIT. THIS FACILITY DOES NOT HAVE ALL COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED. FOOD SERVICE STAFF ARE EMPLOYEES OF FACILITY.

THESE ADDITIONAL TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:

- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- VOMIT CLEAN UP PROCEDURE
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- PASTEURIZED SHELL EGGS

DOCUMENTS ON THE FOLLOWING TOPICS WERE INCLUDED WITH INSPECTION REPORT:

- EMPLOYEE ILLNESS TRACKING
- SAMPLE VOMIT CLEAN UP PROCEDURE
- SAMPLE HANDWASHING SIGN
- HIGH RISK POPULATION REQUIREMENTS

FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD.

Type: Full
Date: 10/19/22
Time: 13:43:25
Report: 1023221189
Aliya Care Inc

Food and Beverage Establishment Inspection Report

Page 3

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 1023221189 of 10/19/22.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed: _____

Establishment Representative

Signed: Gregory T Nelson

Gregory T. Nelson
Public Health Sanitarian
Freeman Building
651-201-4259
greg.nelson@state.mn.us