



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 28, 2025

Licensee

Aliya Care Inc

2700 37th Avenue Northeast

St Anthony, MN 55421

RE: Project Number(s) SL35486016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 26, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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. 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 MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



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

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35486	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/26/2025
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 *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project # SL35486016 On February 24, 2025, through February 26, 2025, 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 two (2) residents receiving services under the Assisted Living License.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35486	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/26/2025
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
0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480			

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 02/26/2025
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
0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 25, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480			

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 02/26/2025
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
0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480			
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which includes documentation of a completed health history and symptom screening, including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of two employees (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	0 660			

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 02/26/2025
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
0 660	Continued From page 4 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: The licensee's TB facility risk assessment dated January 13, 2025, indicated the facility was a low risk for TB. ULP-B was hired September 13, 2024, and provided direct cares for the residents of the facility. ULP-B's record included Baseline Tuberculin Skin Screening for health care worker (HCWs) dated July 9, 2024, and a TST first step date administered November 15, 2024, and date read November 18, 2024. ULP-B's employee record lacked evidence of a second step TST or blood test. During an interview on February 26, 2025, at 1:00 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated ULP-B's employee record was missing a second step TST or blood test. LALD/RN-A stated the licensee had policies and systems in place to ensure compliance with state regulations but was not sure why ULP-B's TB skin or blood testing was not completed. The licensee's Tuberculosis Screening/Prevention policy dated August 1, 2021, indicated "[Licensee] will observe the recommended precautions related to TB prevention as identified by the Centers for	0 660			

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 02/26/2025
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
0 660	Continued From page 5 Disease Control and Prevention (CDC) and the Minnesota Department of Health (MDH). The precautions include the following elements: Risk Assessment, TB Screening, and Staff Education." Also, thee policy indicated "TB testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single TB blood test." The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and the CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. The guidelines also indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff	0 680			

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 02/26/2025
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
0 680	Continued From page 6 assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 680			

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 02/26/2025
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
0 680	Continued From page 7 The licensee's EP plan dated July 2021, consisted of a number of documents and policies contained in a three-ringed binder titled "Assisted Living Emergency Preparedness". The binder included a risk assessment, a communication plan, various policies/procedures, and after-action reviews. The licensee's plan lacked the following required content: - emergency exit diagrams was posted first floor, but was missing second floor (basement); - description of the population served by licensee; - communication plan must include all the following names/contact information: residents' physicians; - 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; - arrangement with other facilities; and - system to track the location of on-duty staff and sheltered residents. During an interview on February 26, 2025, at 1:00 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the provided EP plan was missing customizations for the licensee. LALD/RN-A stated a more complete EP was kept in a locked cabinet in the office and staff have no access. LALD/RN-A acknowledged they should have the info accessible to staff during an emergency. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated "[Licensee] 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."	0 680			

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 02/26/2025
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
0 680	Continued From page 8 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain facility and fire safety equipment in compliance with Minnesota State Fire Code under Minnesota Rules Chapter 7511. This had the potential to affect 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 February 24, 2025, from approximately 11:02 a.m. to 1:00 p.m., the surveyor toured the facility with licensed assisted living director/resident nurse (LALD/RN)-A and observed the following deficient conditions:	0 775			

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 02/26/2025
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
0 775	Continued From page 9 The surveyor requested that LALD/RN-A open windows for measurement in resident rooms. The egress window in resident room 7 and resident room 8 were not readily openable to their full extent because of plastic covers on the respective egress wells that obstructed the windows' ability to open. Window covers should not prevent the egress window from opening to required area to exit the window, nor should windows be otherwise obstructed. The surveyor explained requirements for egress windows to be readily openable and for egress wells to be unobstructed. LALD/RN-A stated that they understood the requirements for egress windows and stated the window cover would be removed. Commercial kitchen hoods were present above the stoves in both kitchens in the facility and these hoods were equipped with a fire suppression system that was not maintained in compliance with requirements. There was no documentation supplied addressing servicing or inspection of the fire suppression system, nor where there any tags documenting required servicing. A sticker on the kitchen hoods indicated a service date in 2018, but no further documentation was available, nor were records provided of more recent servicing. Supplied fire protection equipment must be maintained in proper working order with required annual inspection records. The surveyor explained the requirements for maintaining the supplied equipment. LALD/RN-A indicated that they were not previously aware that system should be serviced but would comply with these requirements moving forward. Several milk crates were stored on a ramp leading out from an egress door from the kitchen on the 2700 37th Ave NE side of the facility.	0 775			

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 02/26/2025
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
0 775	Continued From page 10 Items stored in an egress route may impede ability to exit via that route in an emergency and such routes should be maintained free of obstruction. A microwave was supplied in the kitchen on the 2700 37th Ave NE side of the facility which had a significantly damaged and frayed cord. This cord was damaged to the extent that bare wires were exposed which could contribute to hazard of fire or electrical shock. Supplied electrical equipment should be maintained in safe condition and cords should be protected from physical damage. A multiplug adapter was supplying power to many appliances in the kitchen on the 2700 37th Ave NE side of the facility. The surveyor explained that these appliances should not be powered utilizing a multiplug adapter as they are not rated for that amount of draw and may pose a fire hazard. On February 24, 2025, the surveyor explained the above findings to LALD/RN-A. LALD/RN-A stated they understood the deficient conditions and requirements for compliance and would correct those conditions. TIME PERIOD FOR CORRECTION: Two (2) days	0 775			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment 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	0 780			

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 02/26/2025
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
0 780	Continued From page 11 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 provide and maintain functional smoke alarm interconnection where required in compliance with Minnesota State Fire Code under Minnesota Rules Chapter 7511. This deficient condition had the ability to affect all staff and residents. 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:	0 780			

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 02/26/2025
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
0 780	Continued From page 12 On February 24, 2025, from approximately 11:02 a.m. to 1:00 p.m., the surveyor toured the facility with licensed assisted living director/resident nurse (LALD/RN)-A and during the tour, the surveyor asked LALD/RN-A to test the smoke alarms. LALD/RN-A requested assistance from unlicensed personnel (ULP)-C to test the smoke alarms. The surveyor observed the following deficient conditions: ULP-C tested smoke alarms in resident room 4, resident room 5, bedroom hallway on the 2700 37th Ave NE side of the facility, bedroom hallway on the 2702 37th Ave NE side of the facility, resident room 1, and resident room 7. Upon testing, it was found that the smoke alarms on the main level of the 2700 37th Ave NE side of the facility were interconnected with each other and with the alarm in resident room 7 in the basement, but that no other alarms were properly interconnected such that the activation of those alarms sounds all other smoke alarms in the facility. The supplied smoke alarms in the basement office, resident room 4, resident room 5, and bedroom hallway on the 2702 37th Ave NE side of the facility were not interconnected with any other alarms. On February 24, 2025, the surveyor explained findings on smoke alarm interconnection to LALD/RN-A. LALD/RN who indicated that before testing they believed all smoke alarms were interconnected but acknowledged that they were not properly interconnected so that any smoke alarm activation would cause all smoke alarms in the facility to sound. Interconnection is required such that the activation of any smoke alarm will cause all other alarms to sound.	0 780			

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 02/26/2025
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
0 780	Continued From page 13	0 780			
	TIME PERIOD FOR CORRECTION: Two (2) days				
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the 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 of the residents). The findings include: On February 24, 2025, from approximately 11:02 a.m. to 1:00 p.m., the surveyor toured the facility with licensed assisted living director/resident	0 800			

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 02/26/2025
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 14 nurse (LALD/RN)-A and observed the following conditions: The bathroom nearest resident room 3 had discolored grout along the walls of the shower, that appeared sullied and unclean. The ventilation fan in the bathroom nearest resident room 3 was not maintained in proper order. The fan assembly was covered in dust and the unit made a loud noise when activated. The lock assembly on the egress door leading outside from the kitchen on the 2702 37th Ave NE side of the facility was damaged and not functional to lock the door. The casing around the lock had come loose and was chipped with a sharp metal edge sticking out that was sharp to the touch and had the potential to injure someone reaching for the lock. LALD/RN verified the damage by touching the sharp piece of metal from the locking assembly. There was a small pool of water on the floor of the water meter room near resident room 7, which was indicated by LALD/RN-A to have resulted from a leak that has reportedly been repaired. Plumbing should be maintained free of leaks. During the facility tour on February 24, 2025, these deficient conditions were visually verified by LALD/RN-A accompanying on the tour and they stated they understood requirements to comply with property maintenance conditions. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			

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 02/26/2025
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
0 810	Continued From page 15	0 810			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire	0 810			

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 02/26/2025
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
0 810	Continued From page 16 safety and evacuation plan (FSEP) with the required content and provide room numbers, the required employee training and resident fire procedures. 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 potential to affect a large portion or all of the residents). The findings include: On February 24, 2025, at approximately 12:35 p.m. licensed assisted living director/resident nurse (LALD/RN)-A provided documentation on the fire safety and evacuation plan (FSEP) to the surveyor. The licensee's FSEP failed to include the following: The FSEP was located in the staff office, a space which according to LALD/RN-A, is locked on occasion, and within that office was located in a locked filing cabinet. The FSEP must be stored in a location where it is readily available at all times in the facility. LALD/RN-A stated that the facility has plans to move the FSEP to an area near the front door. The FSEP did not include documentation of resident room numbers. The FSEP did not identify specific fire protection actions for residents. There was no section in the	0 810			

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 02/26/2025
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
0 810	Continued From page 17 policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP did not include adequate record of adequate training for facility staff on the FSEP. Staff Training Record dated 5/22/24 was provided, but no other staff training documents were supplied to the surveyor. LALD/RN-A stated that that staff is trained annually on the FSEP. Staff is required to receive raining upon hire and twice a year thereafter on the FSEP. During interview on February 24, 2025, the surveyor explained the requirements for proper storage and availability of the FSEP, resident procedures and frequency of employee training. LALD/RN stated they understood the requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this	01530			

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 02/26/2025
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
01530	Continued From page 18 initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct-care staff completed the required amount of dementia care training in the required time frame for one of two employees (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 was hired September 13, 2024, and provided direct cares for the residents of the facility. ULP-B's EduCare (online training platform) transcript dated October 10, 2024, and January	01530			

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 02/26/2025
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
01530	Continued From page 19 13, 2025, indicated ULP-B completed (4) four hours of dementia care training. ULP-B's employee record lacked evidence ULP-B had completed the required eight (8) hours of dementia training on the specific dementia care topics within 160 working hours of the employment start date. During an interview on February 26, 2025, at 1:00 p.m., licensed assisted living director/registered nurse (LALD/RN)-A acknowledged ULP-B's record lacked evidence they completed the required eight (8) hours of dementia training within 160 working hours of the employment start date. LALD/RN-A stated she thought ULP-B completed 8 hours dementia training and it was brought to his attention today when she realized the training was not completed. The licensee's Dementia Education policy dated August 1, 2021, indicated "Direct care employees must have completed at least eight (8) hours of initial education within 160 working hours of the employment start date." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the	01620			

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 02/26/2025
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
01620	Continued From page 20 resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment not to exceed 90 days from the date of the last assessment 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 a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01620			

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 02/26/2025
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
01620	Continued From page 21 R1 admitted to the licensee on July 10, 2024, with diagnoses included chronic back pain, anxiety, and post-traumatic stress disorder (PTSD). R1's service plan dated July 10, 2024, indicated R1 received services which included assistance with activity daily living (ADL) and medication reminders. R1's medical record include a Resident Evaluation (Nursing Assessment) dated July 10, 2024, and Nurse Reassessment visits dated July 24, 2024; August 9, 2024; and November 21, 2024. R1's ongoing resident reassessment and monitoring completed on November 21, 2024, exceed 90 calendar days from the last dated August 9, 2024. During an interview on February 26, 2025, at 1:00 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated R1's Nurse Reassessment visit completed on November 21, 2024, exceeded 90 calendar days from the last assessment dated August 9, 2024, by twelve days. The licensee's Comprehensive Nursing Assessment policy dated August 1, 2021, indicated "The RN will conduct a comprehensive assessment utilizing a uniform assessment tool". No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620			

Type: Follow-Up
Date: 03/10/25
Time: 10:43:11
Report: 1021251058

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: Yes

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.

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Cold Holding

Temperature: 38 Degrees Fahrenheit - Location: MILK - KITCHEN REFRIGERATOR #1

Violation Issued: No

Process/Item: Ambient Temperature

Temperature: 35 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR #1

Violation Issued: No

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

TODAY'S FOLLOW UP WAS TO ADDRESS AND CLEAR PREVIOUSLY WRITTEN ORDERS FROM A FULL INSPECTION CONDUCTED ON 02/25/25. 5 OUT OF 5 ORDERS WERE CLEARED FROM THE REPORT.

Type: Follow-Up
Date: 03/10/25
Time: 10:43:11
Report: 1021251058
Aliya Care Inc

Food and Beverage Establishment Inspection Report

Page 2

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 1021251058 of 03/10/25.

Certified Food Protection Manager JULIA M. PASSMORE

Certification Number: FM114068 Expires: 11/10/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

KHADRA ISMAIL
RN / LALD

Signed: _____

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

Type: Full
Date: 02/25/25
Time: 11:03:24
Report: 1021251044

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: Yes

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.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ** Priority 1 **

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

A CARTON OF RAW SHELL EGGS FOUND STORED ABOVE A GALLON OF MILK AND A CONTAINER OF JUICE IN THE KITCHEN REFRIGERATOR #2. THE RAW SHELL EGGS WERE MOVED TO A BOTTOM SHELF TO PREVENT ANY CROSS CONTAMINATION. CORRECTED ON-SITE.

Comply By: 02/25/25

3-500B Microbial Control: hot and cold holding

3-501.16A2 ** Priority 1 **

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

THE GALLON OF MILK IN THE KITCHEN REFRIGERATOR #1 MEASURED 46F. THE AMBIENT TEMPERATURE OF THE REFRIGERATOR MEASURED 47F. STAFF ADJUSTED THE TEMPERATURE OF THE REFRIGERATOR AND WILL MONITOR ALL TCS FOODS.

Comply By: 02/25/25

7-200 Toxic Supplies and Applications

7-204.11 ** Priority 1 **

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

ESTABLISHMENT HAS A CONTAINER OF BLEACH ON-SITE BUT IS NOT APPROVED WITH

Type: Full
Date: 02/25/25
Time: 11:03:24
Report: 1021251044
Aliya Care Inc

Food and Beverage Establishment Inspection Report

Page 2

FOOD CONTACT SURFACES. REPLACE THE SPLASHLESS BLEACH WITH AN APPROVED ONE.
Comply By: 02/25/25

4-300 Equipment Numbers and Capacities

4-302.14 **** Priority 2 ****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
NO TEST KIT ON-SITE TO MEASURE THE CONCENTRATION OF CHLORINE. PROVIDE.
Comply By: 03/04/25

6-300 Physical Facility Numbers and Capacities

6-301.12 **** Priority 2 ****

MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.
NO PAPER TOWELS AT THE KITCHEN HANDWASHING SINK. STAFF PROVIDED PAPER TOWELS DURING INSPECTION. CORRECTED ON-SITE. MAINTAIN A SUPPLY OF PAPER TOWELS AT ALL HANDWASHING SINKS DURING ALL HOURS OF OPERATION.
Comply By: 02/25/25

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 46 Degrees Fahrenheit - Location: MILK - KITCHEN REFRIGERATOR #1
Violation Issued: Yes

Process/Item: Ambient Temperature
Temperature: 47 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR #1
Violation Issued: Yes

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: MILK - KITCHEN REFRIGERATOR #2
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: SPINACH - KITCHEN REFRIGERATOR #2
Violation Issued: No

Process/Item: Ambient Temperature
Temperature: 40 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR #2
Violation Issued: No

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

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH LALD, KHADRA ISMAIL AND HEALTH REGULATION DIVISION NURSE EVALUATOR, SAFIA HASSAN.

THIS FACILITY IS A RESIDENTIAL HOME AND THEY CURRENTLY HAVE 2 CLIENTS AND THE FACILITY CAN HAVE UP TO 8 CLIENTS.

Type: Full
Date: 02/25/25
Time: 11:03:24
Report: 1021251044
Aliya Care Inc

Food and Beverage Establishment Inspection Report

Page 3

THE KITCHEN HAS RESIDENTIAL EQUIPMENT AND TEXTURED CEILING. PHYSICAL FACILITY ITEMS WILL BE MONITORED DURING FUTURE INSPECTIONS.

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 1021251044 of 02/25/25.

Certified Food Protection Manager JULIA M. PASSMORE

Certification Number: FM114068 Expires: 11/10/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

KHADRA ISMAIL
RN / LALD

Signed: _____

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