Electronically Delivered

October 23, 2023

Licensee
Mount Zion Care Services, LLC
3751 Ridge Avenue
Anoka, MN 55303

RE: Project Number(s) SL39302015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on September 29, 2023, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance 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

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

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

Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,

Carrie Euerle, Supervisor
State Rapid Response Team
Email: carrie.euerle@state.mn.us
Telephone: 651-242-8846 Fax: 1-800-337-9238

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39302	A. BUILDING: _____ B. WING _____	09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT ZION CARE SERVICES LLC	3751 RIDGE AVENUE ANOKA, MN 55303

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#: SL39302015 On September 25, 2023, 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 and investigation, there were 2 residents receiving services under the provider's Provisional Assisted Living Facility 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 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents:	0 480		

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0 480	Continued From page 1 (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 September 27, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure,	0 650		

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0 650	Continued From page 2 registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure current employee records were maintained to include the required content of a background study clearance letter, for one of two employees (registered nurse (RN)-D) with 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: Registered Nurse (RN)-D was hired on March 6,	0 650		

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0 650	Continued From page 3 2023 to provide direct care and services to the licensee's residents and to provide oversight and supervision to the licensee's unlicensed personnel. RN-D's personnel file lacked evidence of the following required content: documentation of the background study as required under section 144.057. During an interview on September 27, 2023 at 3:02 p.m., the licensed assisted living director, (LALD)-A stated a background study clearance letter for RN-D was not sent to the licensee when completed. LALD-A stated the licensee researched the background study on-line and copied findings for RN-D's personnel file. LALD-A stated she was not aware the employee file was required to have the above mentioned content. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 650		
0 680 SS=D	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;	0 680		

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0 680	Continued From page 4 (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 disaster plan with all required content. This had the potential to 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, 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 entrance conference on September 25, 2023 at 11:58 a.m., the licensee's emergency preparedness plan was reviewed. The surveyor reviewed the emergency preparedness plan with licensed assisted living director, (LALD)-A. The	0 680		

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0 680	Continued From page 5 licensee's emergency preparedness plan was kept in a manual resource and the LALD-A was indicated as the incident command. LALD-A sent the emergency preparedness plan to the surveyor, via email, on September 26, 2023 at 9:43 a.m. for review. The surveyor reviewed the licensee's emergency prepared plan on September 27, 2023 at 1:28 p.m. The surveyor's review identified the licensee's emergency preparedness plan lacked the following components: -Methods for sharing information: verification of communication plan has a policy and procedure to address the means the licensee will be utilized to release resident information. The licensee provided Emergency Preparedness Plan Policy, dated November 1, 2022, indicated under Shelter in Place, Background, No. 4. A plan would be developed to address the medical needs of the residents including securing medical records, access to pharmaceuticals, medical supplies and equipment needed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 680		
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	0 790		

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0 790	Continued From page 6 minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: The licensee failed to provide the required annual maintenance on fire extinguishers. 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 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). Findings include: On September 27, 2023, at approximately 1:00 p.m., survey staff toured the facility with the Assisted Living Director (LALD)-A. During the facility tour, survey staff observed that portable fire extinguishers on both levels were not provided with tags or labels from certified service personnel indicating that annual maintenance had been performed. This deficient condition was visually verified by LALD-A accompanying the tour. TIME PERIOD FOR CORRECTION: Seven (7)	0 790		

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0 790	Continued From page 7 days	0 790		
0 800 SS=E	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: The licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On September 27, 2023, at approximately 1:00 a.m., survey staff toured the facility with Licensed Assisted Living Director (LALD)-A. During the facility tour, survey staff observed the	0 800		

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0 800	Continued From page 8 following: -In resident bedrooms #1 and #3, it was observed that the doors were heavily damaged and had holes. During the interview, LALD-A stated that the damage was caused by the resident's wheelchair and visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at	0 810		

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0 810	Continued From page 9 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: The licensee failed to provide a fire protection procedure necessary for residents and failed to provide required employee training on fire safety and evacuation. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: An interview and record review were conducted on September 27, 2023, at approximately 1:00 p.m. with the Licensed Assisted Living Director (LALD)-A on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan.	0 810		

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0 810	Continued From page 10 During the interview, LALD-A verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that employees did not receive training twice per year after initial hire. During the interview, LALD-A stated that the licensee provided annual training to employees, but not twice per year after the initial hire, on the fire safety and evacuation plan, as required by statute. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
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 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	01620		

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01620	Continued From page 11 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 nursing assessment (initial assessment) was completed by the registered nurse (RN) in accordance with Minnesota (MN) Statute 144G.08 subd. 9, clause (6-12) regulatory guidelines for one of two residents (R1) with records reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings included: R1 admitted to licensee on January 12, 2023, with diagnoses of spinal disease, and diabetes mellitus type II. R1's service plan, dated July 12, 2023, indicated R1 required assistance with personal cares, transfers, eating, medication management, laundry, housekeeping, and safety checks. R1 used a wheelchair for mobility and transferred using a slide board or mechanical lift and the assist of two staff persons. R1's initial assessment dated July 13, 2023,	01620		

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01620	Continued From page 12 indicated R1's assessments including assistance with activities of daily living, (ADLs), medication management plan, self-administration assessment, smoking assessment, and side rail assessment had been been completed. The licensed assisted living director (LALD)-A, who was also a registered nurse (RN), indicated in an email, sent on September 28, 2023, at 9:52 a.m., R1 had moved in to the licensee's facility on January 12, 2023, with a lot to un-pack, thus the initial assessment could not be completed until the next day, January 13, 2023. The licensee provided policy dated November 1, 2022, indicated under: Procedure (1) The initial RN assessment shall be completed prior to the date on which the prospective resident executes a contract or on the date which the resident moves in. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01870 SS=D	144G.71 Subd. 18 Medications provided by resident or family me When the assisted living facility is aware of any medications or dietary supplements that are being used by the resident and are not included in the assessment for medication management services, the staff must advise the registered nurse and document that in the resident record. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01870		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39302	A. BUILDING: _____ B. WING _____	09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT ZION CARE SERVICES LLC	3751 RIDGE AVENUE ANOKA, MN 55303

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01870	Continued From page 13 licensee failed to ensure assessments for safe self-administration of medications were completed for one of two residents (R1) who self-administered medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R1 admitted to the licensee on January 12, 2023, with diagnoses of spinal disease, diabetes mellitus type II, and neurogenic bowel and bladder. R1's Service Plan Agreement dated January 12, 2023, indicated R1 received services, which included medication administration. R1's progress notes, dated February 17, 2023, at 8:54 p.m., indicated R1 self-administered Ozempic. R1's progress notes, dated April 7, 2023, at 5:28 p.m., indicated R1 self-administered Ozempic despite staff asking R1 to wait. R1's 90-day nursing assessment, dated April 14, 2023, indicated R1's medications were stored in a locked medication cabinet and staff administered R1's medications. R1's medication self-administration assessment,	01870		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01870	Continued From page 14 dated September 12, 2023, completed by the registered nurse (RN), indicated R1 was assessed as not able to self-administer medications. On September 26, 2023 at 2:26 p.m., the Minnesota Department of Health (MDH) surveyor observed R1 to have an inhaler at her bedside. During an interview, on September 26, 2023, at 2:26 p.m., unlicensed personnel (ULP)-C, indicated R1 kept the inhaler at her bedside and self-administered the inhaler when short of breath. R1's medication administration records (MAR) dated August 2023, included physician's orders for: - Albuterol Sulfate Hfa Inhaler, inhale one puff by mouth (po) every six hours as needed for shortness of breath. -Ozempic (one milligram (mg) dose), inject one subcutaneously one time per week. Please bring Ozempic to the resident and remind to self-administer on Friday evening (PM) shift. Resident may self-administer per physician. R1's MAR dated September 2023, lacked evidence of the order for: Albuterol Sulfate Hfa Inhaler, inhale one puff by mouth (po) every six hours as needed for shortness of breath. R1's MAR dated September 2023, indicated the following: -Ozempic (one milligram (mg) dose), inject one subcutaneously one time per week. Please bring Ozempic to the resident and remind to self-administer on Friday evening (PM) shift. Resident may self-administer per physician.	01870		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39302	A. BUILDING: _____ B. WING _____	09/29/2023

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01870	Continued From page 15 R1's physician orders, dated January 12, 2023, indicated Ventolin inhaler Hfa Aerosol Solution 108, one puff orally every six hours as needed for shortness of breath. During an interview, on September 26, 2023, at 2:26 p.m., the licensed assisted living director, (LALD)-A, who was also a registered nurse (RN), stated R1 had physician orders to self-administer the Albuterol Inhaler. LALD-A produced physician orders which indicated R1's ability to self-administer the inhaler as needed. During the interview, the MDH surveyor observed and requested a copy of R1's physician's orders. A licensee provided Medication Management Policy dated 2021, indicated the registered nurse would determine the resident's need for assistance with medication administration. A licensee provided Verbal Reminders for Medications Policy dated November 1, 2022, indicated: Procedure (1) During an assessment the registered nurse will determine the level of assistance required for residents related to medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01870		

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul
6512014500

Type: Full
Date: *09/26/23*
Time: 11:15:11
Report: 1029231251

Food and Beverage Establishment Inspection Report

Location:

MOunt Zion Care Services LLC
3751 Ridge Avenue
Anoka, MN55303
Anoka County, 02

Establishment Info:

ID #: 0042088
Risk:
Announced Inspection: Yes

License Categories:

Expires on: 12/31/23

Operator:

Phone #:
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.

3-500B 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.

Temperature abused TCS foods identified in refrigerator. were discarded and refrigerator was adjusted. Operator was instructed to not store TCS items in refrigerator until consistent safe temperatures were verified.

Comply By: 09/26/23

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 strips to test chlorine sanitizer solution. Instructed operator to obtain test strips.

Comply By: 09/26/23

Surface and Equipment Sanitizers

chlorine: = 150 ppm at Degrees Fahrenheit
Location: sanitizer bucket
Violation Issued: No

Food and Equipment Temperatures

Process/Item: sliced cheese
Temperature: 46 Degrees Fahrenheit - Location: refrigerator
Violation Issued: Yes

Process/Item: sliced cheese
Temperature: 45 Degrees Fahrenheit - Location: refrigerator
Violation Issued: Yes

Process/Item: pickle juice (non-TCS)
Temperature: 49 Degrees Fahrenheit - Location: refrigerator
Violation Issued: No

Process/Item: internal thermometer
Temperature: 46 Degrees Fahrenheit - Location: refrigerator
Violation Issued: No

Process/Item: milk
Temperature: 47 Degrees Fahrenheit - Location: refrigerator
Violation Issued: Yes

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

Conducted inspection with Azie Khan, Assisted Living Director and CFPM. All identified issues were discussed with Azie throughout the inspection. Topics discussed with Azie during the inspection included employee illness reporting and exclusion procedures, vomit/fecal matter cleanup, highly susceptible populations, sanitizing, date marking effectively, common contagious foodborne illness pathogens (e.g., salmonella, shigella, Shiga toxin-producing E. coli, hepatitis A virus, and norovirus), hygienic practices (e.g., handwashing), and general food safety practices (e.g., holding temperatures at or below 41°F and 135° F or above for TCS foods).

The kitchen was non-commercial in nature. The kitchen area had pergo-esque laminate flooring, stone counter tops, tile backsplash, composite wood cabinetry and drawers with laminate coverings, and painted ceiling with slight texture. The kitchen was in excellent condition and clean to sight and touch.

Inspection findings conveyed to Lori Pokela, RN BS HCM, Special Investigator, Nurse Evaluator.

Type: Full
Date: *09/26/23*
Time: 11:15:11
Report: 1029231251
MOunt Zion Care Services LLC

Food and Beverage Establishment Inspection Report

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 1029231251 of 09/26/23.

Certified Food Protection Manager: Azie J. Khan

Certification Number: FM111711 Expires: 06/11/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Azie Khan
Assisted Living Director

Signed: _____
Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Report #: 1029231251

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul

No. of RF/PHI Categories Out	1	**Date**	09/26/23
No. of Repeat RF/PHI Categories Out	0	**Time In**	11:15:11
Legal Authority MN Rules Chapter 4626		**Time Out**	

MOunt Zion Care Services LLC	**Address** 3751 Ridge Avenue	**City/State** Anoka, MN	**Zip Code** 55303	**Telephone**
License/Permit # 0042088	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN OUT	PIC knowledgeable; duties & oversight		
2	IN OUT N/A	Certified food protection manager, duties		
	Employee Health			
3	IN OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4	IN OUT	Proper use of reporting, restriction & exclusion		
5	IN OUT	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices			
6	IN OUT N/O	Proper eating, tasting, drinking, or tobacco use		
7	IN OUT N/O	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands			
8	IN OUT N/O	Hands clean & properly washed		
9	IN OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN OUT	Adequate handwashing sinks supplied/accessible		
	Approved Source			
11	IN OUT	Food obtained from approved source		
12	IN OUT N/A N/O	Food received at proper temperature		
13	IN OUT	Food in good condition, safe, & unadulterated		
14	IN OUT N/A N/O	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
15	IN OUT N/A N/O	Food separated and protected		
16	IN OUT N/A	Food contact surfaces: cleaned & sanitized		
17	IN OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	IN OUT N/A N/O	Proper cooking time & temperature		
19	IN OUT N/A N/O	Proper reheating procedures for hot holding		
20	IN OUT N/A N/O	Proper cooling time & temperature		
21	IN OUT N/A N/O	Proper hot holding temperatures		
22	IN OUT N/A	Proper cold holding temperatures		
23	IN OUT N/A N/O	Proper date marking & disposition		
24	IN OUT N/A N/O	Time as a public health control: procedures & records		
	Consumer Advisory			
25	IN OUT N/A	Consumer advisory provided for raw/undercooked food		
	Highly Susceptible Populations			
26	IN OUT N/A	Pasteurized foods used; prohibited foods not offered		
	Food and Color Additives and Toxic Substances			
27	IN OUT N/A	Food additives: approved & properly used		
28	IN OUT	Toxic substances properly identified, stored, & used		
	Conformance with Approved Procedures			
29	IN OUT N/A	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
		Safe Food and Water		
30	IN OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 10/02/23

Inspector (Signature) Trevor L McClimint