



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 9, 2025

Licensee

Mount Zion Care Services LLC

3751 Ridge Avenue

Anoka, MN 55303

RE: Project Number(s) SL39302016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 29, 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 . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement;

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in

§ 144G.20;

Level 5: a fine of \$5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

0510 - 144g.41 Subd. 3 - Infection Control Program - \$500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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/Bm5uQEpHV>**. 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,



Kelly Thorson, Supervisor

State Evaluation Team

Email: kelly.thorson@state.mn.us

Telephone: 320-223-7336 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39302	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/29/2025
NAME OF PROVIDER OR SUPPLIER MOUNT ZION CARE SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3751 RIDGE AVENUE ANOKA, MN 55303			
(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(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: SL39302016-0 On August 25, 2025, through August 29, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were four (4) residents; four (4) receiving services under the 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.		
0 510 SS=F	144G.41 Subd. 3 Infection control program	0 510			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 510	Continued From page 1 (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b) The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain an effective infection control program to comply with acceptable health care, medical, and nursing standards for infection control by one of two employees (unlicensed personnel (ULP)-C). 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 the residents). The findings include: ULP-C was hired March 6, 2023, to provide direct care services to residents of the assisted living facility.	0 510			

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0 510	Continued From page 2 On August 25, 2025, from 12:15 p.m., through 12:31 p.m., during continuous observation surveyor observed ULP-C apply gloves and started to prepare the lunch meal for the residents of the facility, without changing gloves or washing hands, she went to the medication cabinet and proceeded to start medication administration for a resident. The resident poked his head in from the garage and advised that he had an appointment and would take his medications when he returned. ULP-C put the medications back into the cabinet, wearing the same gloves, went and signed the resident out of the facility in a logbook. ULP-C then returned to the kitchen and continued to prepare the lunch meal while wearing the same gloves. A call button alarmed for resident (R2), who was outside in his wheelchair smoking, and ULP-C went outside wearing the same pair of gloves to answer the call button alarm for R2 and proceeded to push R2's wheelchair into the front door and to the dining room table. ULP-C returned to the kitchen and finished preparing the lunch meal and wearing the same gloves served R2's meal. ULP-C then proceeded to the living room where R1 was watching television and wearing the same gloves proceeded to push R1's wheelchair to the dining room table, served R1's meal, and then poured juice for both residents. ULP-C doffed the gloves and then washed her hands at the kitchen sink. On August 25, 2025, at 1:10 p.m., ULP-C stated she had completed infection control training on handwashing and glove use but did not wash her hands prior to applying the gloves but did wash them after taking them off. ULP-C stated she had forgotten to sanitize her gloved hands in between tasks and did not realize that you should not use	0 510			

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0 510	Continued From page 3 sanitizer on gloved hands. On August 27, 2025, at 11:45 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she goes over infection control techniques with the staff at least quarterly. LALD/CNS-A stated she would expect staff to wash hands before and after glove use and to change gloves and wash hands in between tasks and if this was not followed it would be due to employee negligence. The Centers for Disease Control and Prevention's (CDC), Hand Hygiene for Healthcare Workers, dated February 27, 2024, indicated gloves are not a substitute for hand hygiene. - if your task requires gloves, perform hand hygiene before donning gloves and touching the patient or the patient's surroundings. - always clean your hands after removing gloves. - remember to remove gloves carefully to prevent hand contamination as dirty gloves can soil hands. When to wear gloves: - when needed for Standard Precautions (when you anticipate that you will come in contact with blood or other infectious materials, mucous membranes, non-intact skin, potentially contaminated skin, or contaminated equipment). - when needed for Transmission-Based Precautions. When to change gloves and clean hands: - if gloves become damaged. - if gloves become soiled with blood or body fluids after a task. - if moving from work on a soiled body site to a	0 510			

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0 510	Continued From page 4 clean body site on the same patient or if a clinical indication for hand hygiene occurs. - if moving from care on one patient to another patient. - if they look dirty or have blood or body fluids on them after completing a task. - before exiting a patient room. The licensee's Infection Control policy dated, November 1, 2022, indicated the licensee will observe the recommended precautions for home care as identified by the CDC. The practice of employees will conform with OSHA regulations, current law and currently accepted health care, medical and nursing standards of practice for infection control. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced	0 630			

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0 630	Continued From page 5 by: Based on interview and record review, the licensee failed to develop an individual abuse prevention plan (IAPP) with the required content for two of three residents (R1 and R2). 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: R1 R1 was admitted to the licensee on January 4, 2024. R1's IAPP dated June 27, 2025, indicated R1 was at risk to be abused but did not include: - assessment of the resident's risk of abusing other vulnerable adults or minors; and - statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. R2 R2 was admitted to the licensee on December 21, 2024. R2's IAPP dated July 25, 2025, indicated R2 was at risk to be abused but did not include: - assessment of the resident's risk of abusing other vulnerable adults or minors; and - statements of specific measures to be taken to	0 630			

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0 630	Continued From page 6 minimize the risk of abuse to that person and other vulnerable adults. On August 27, 2025, at 12:15 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she is aware of some of the IAPP requirements, agrees that the IAPP's for R1 and R2 are missing the full requirements, and will update them to include the missing information. The licensee's Vulnerable Adult policy dated November 1, 2022, indicated an individual abuse prevention plan shall be established for each vulnerable minor or adult for whom assisted living facility services are provided. The plan shall contain an individualized assessment of the resident's susceptibility to abuse by another individual, including other vulnerable adults. The plan shall contain the resident's risk of abusing other vulnerable adults. The plan shall contain statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 660 SS=E	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	0 660			

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0 660	Continued From page 7 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 observation, 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 included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test, for two of two employees (unlicensed personnel (ULP)-C and (ULP)-D). 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: The licensee's Facility Tuberculosis (TB) Risk Assessment dated April 20, 2025, indicated licensee was low risk level.	0 660			

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0 660	Continued From page 8 ULP-C ULP-C began employment on March 6, 2023, to provide direct care to residents. ULP-C's employee record contained a negative TB chest x-ray dated March 8, 2023. On August 25, 2025, at 12:00 p.m., the surveyor observed ULP-C provide medication administration to resident (R2). ULP-D ULP-D began employment on October 28, 2022, to provide direct care to residents. ULP-D's employee record contained a negative TB chest x-ray dated December 9, 2022. ULP-C and ULP-D's employee records both lacked evidence of a TB baseline screening which included a two-step tuberculin skin test (TST) or other blood test with a positive result, to indicate the need for the chest x-ray. The Minnesota Department of Health's (MDH) Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated baseline TB screening is required at the time of hire for all health care personnel to include: - assessing for current symptoms of active TB disease; - assessing TB history; and - testing for the presence of Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or single TB blood test also indicated. also indicated a chest x-ray alone is not acceptable documentation. You either need: - documentation of a positive two-step Tuberculin	0 660			

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0 660	Continued From page 9 Skin Test (TST) or Interferon-Gamma Release Assay (IGRA) test; and - a chest x-ray with provider evaluation after that date; or - documentation of refusal of both the two-step TST and IGRA; and - followed by a new chest x-ray and provider evaluation. On August 28, 2025, at 2:10 p.m., the licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she agrees the employee TB testing is not in compliance and did not realize that a chest x-ray alone was not allowed for employee TB testing. The licensee's TB Screening/Prevention policy updated November 1, 2022, indicated the licensee will observe the recommended precautions related to TB prevention as identified by the Centers for Disease Control and Prevention (CDC) and the Minnesota Department of Health (MDH). 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 assignments in the event of a disaster or an	0 680			

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0 680	Continued From page 10 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 develop an all-hazards risk assessment emergency preparedness program and plan to include Appendix Z required elements. 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include:	0 680			

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0 680	Continued From page 11 The licensee's undated emergency preparedness plan (EPP), lacked the required content: - a quarterly review of missing resident policy; - a description of the population served by the licensee; - process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - the development of policies/procedures to address: - procedures for tracking of staff and patients; - procedures for medical documents; - use of volunteers; - arrangement with other facility; and - role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act. - names and contact information for staff entities providing services; residents physicians, other facilities, and volunteers; - contact information for federal, state, tribal, local EP staff, state licensing and certification agency, or the ombudsman for long term care; - primary and alternative means for communicating with facility staff, or federal, state, regional and local emergency management agencies; - methods for sharing medical documentation for residents under the facility's care, as necessary, with other health care providers to maintain continuity of care; - means to provide information about the facility's occupancy, needs, and its ability to provide assistance to the authority having jurisdiction, the incident command center, or a designee; - communication plan must include method for sharing information from the emergency plan, that the facility has determined appropriate, with	0 680			

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0 680	Continued From page 12 residents and their families/representatives; and - evidence of conducted exercises to test the EP at least twice per year. On August 27, 2025, at 11:55 a.m., licensed assisted living facility/clinical nurse supervisor (LALD/CNS)-A stated they are responsible for the EPP and was not aware the missing person policy needed to be reviewed quarterly. In addition, on August 28, 2025, at 2:00 p.m., LALD/CNS-A stated after looking at all the required information that needs to be in the EPP, she agrees that the EPP is missing some of this information and will need to update the EPP and does not have documentation that the EPP has been tested twice annually. The licensee's Emergency Preparedness policy dated October 1, 2022, indicated the 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. A disaster drill is conducted at the residence at the residence at least annually. Results of the drill will be documented. The licensee's Missing Resident policy dated October 1, 2022, indicated the missing resident procedure will be reviewed by the director and clinical nurse supervisor at least quarterly. Changes to the plan will be documented. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subd. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly. Changes to the plan will be documented.	0 680			

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0 680	Continued From page 13 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 775 SS=E	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, interview, and record review the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511. 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 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 August 26, 2025, at 10:40 a.m., the surveyor toured the facility with unlicensed personnel (ULP)-E. During the tour, the surveyor observed the following: - In occupied resident room 1 on the main floor, a large volume of personal items were stored in	0 775			

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0 775	Continued From page 14 front of the egress window. - In occupied resident rooms 4 and 5 in the basement, personal items were stored on the egress window sills. During the facility tour interview, ULP-E verified the above listed observations. Egress windows are required to be maintained clear of obstructions that would prevent immediate and full use of the window in the event of a fire or similar emergency. TIME PERIOD FOR CORRECTION: Two (2) days	0 775			
0 780 SS=A	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to	0 780			

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0 780	Continued From page 15 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 a smoke alarm that complied with fire protection requirements. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On August 26, 2025, at 10:40 a.m., the surveyor toured the facility with unlicensed personnel (ULP)-E. During the tour, the surveyor observed when the interconnected smoke alarms were tested, the smoke alarm was not actuated in the basement mechanical room. All smoke alarms installed in the dwelling unit must be interconnected so actuation of one alarm causes all alarms in the dwelling unit to operate. During an interview on August 28, 2025, at 1:00 P.M., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A verified the above	0 780			

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0 780	Continued From page 16 listed smoke alarm observation. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 800 SS=B	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 provide 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 practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect 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 August 26, 2025, at 10:40 a.m., the surveyor	0 800			

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0 800	Continued From page 17 toured the facility with unlicensed personnel (ULP)-E. During the tour, the surveyor observed the following: - In resident room 2, there was a small hole in the wall behind the armchair. - In the private bathroom for resident room 5, the towel bar was missing from the wall and the ceiling finish was starting to peel in a limited area outside of the shower stall. - In the basement bathroom, the towel bar was missing from the wall and the roller bar for the toilet paper holder was missing. - There was a small hole in the wall at the base of the stairs. During the facility tour interview, ULP-E verified the above listed observations. 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) 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	0 810			

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0 810	Continued From page 18 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 safety and evacuation plan with required content, and provide required training and drills. 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).	0 810			

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0 810	Continued From page 19 The findings include: On August 26, 2025, unlicensed personnel (ULP)-E provided documents on the fire safety and evacuation plan (FSEP) for the facility. On August 27 and 28, 2025, licensed assisted living director/clinical nurse supervisor (LALD)/CNS-A provided records on fire safety and evacuation training and fire drills for the facility On August 26, 2025, at 10:40 a.m., the surveyor toured the facility with unlicensed personnel (ULP)-E. During the tour, the surveyor observed the following: - Room number identifiers were posted at each resident room door. The emergency evacuation floor plan posted in the basement did not include room number labels for resident rooms 4 and 5. Resident room numbers are required to be included on the FSEP floor plan and correspond with the numbers installed at the resident room doors to provide efficient communication for exiting in the event of a fire or similar emergency. - An exit sign was posted at the door leading into the attached garage. Record review indicated the door leading into the attached garage was labeled as emergency exit 2 on the evacuation floor plans posted in the facility. Emergency exits are required to lead directly to the exterior of the building and not through a higher-hazard room. FIRE SAFETY AND EVACUATION PLAN Record review of the available documentation indicated the licensee failed to develop the FSEP with site specific procedures for the assisted living facility and the building occupants. The FSEP included a fire safety policy dated October 1, 2022, that was a template from a third party provider. Pull fire alarms were inaccurately	0 810			

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0 810	Continued From page 20 referenced. Record review indicated the emergency evacuation facility diagram in the emergency preparedness manual binder did not accurately identify the location of resident bedrooms 4 and 5 in the basement. The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The employee actions were limited to the RACE (Remove, Alarm, Confine, Extinguish/Evacuate) acronym. The FSEP failed to include fire safety and evacuation instructions for residents evident by limited directions for residents to stoop or crawl to avoid smoke. The FSEP failed to include site specific resident evacuation and movement procedures during a fire or similar emergency evident by vague instructions for employees to assist residents during an evacuation. Record review indicated the FSEP did not include evacuation procedures for the individualized unique needs of residents. The Mount Zion care services fire safety policy dated October 1, 2022, referenced resident levels for evacuation and the employee procedures were limited to assiting residents out of the building. Record review indicated residents identified as requiring employee assistance during an evacuation were not maintained. The evacuation status reports were dated February 3, 2023, and January 14, 2023. During an interview on August 28, 2025, at 1:00	0 810			

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0 810	Continued From page 21 p.m., LALD/CNS-A verified the FSEP required revision. TRAINING Record review indicated the licensee failed to provide training to employees on the site specific FSEP at least twice per year evident by training documentation lacking the required frequency and content. An employee training record dated June 1, 2024, was provided. This record indicated a third party fire safety and evacuation training had been completed. No additional training documentation was provided. During an interview on August 28, 2025, at 1:00 p.m., LALD/CNS-A verified the FSEP employee training frequency was not met and stated employees were trained on the FSEP at the time of hire and then annually. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees every other month evident by a review of completed fire drill audit reports lacking the required frequency. Eleven fire drills were recorded in 2024, these drills were completed in February, June, and August. Seven fire drills were recorded in 2025, these drills were completed in January and May. During an interview on August 28, 2025, at 1:00 p.m., LALD/CNS-A verified the fire evacuation drill frequency was not met. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 990 SS=D	144G.52 Subd. 2 Prerequisite to termination of a contract	0 990			

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0 990	Continued From page 22 (a) Before issuing a notice of termination of an assisted living contract, a facility must schedule and participate in a meeting with the resident and the resident's legal representative and designated representative. The purposes of the meeting are to: (1) explain in detail the reasons for the proposed termination; and (2) identify and offer reasonable accommodations or modifications, interventions, or alternatives to avoid the termination or enable the resident to remain in the facility, including but not limited to securing services from another provider of the resident's choosing that may allow the resident to avoid the termination. A facility is not required to offer accommodations, modifications, interventions, or alternatives that fundamentally alter the nature of the operation of the facility. (b) For a termination pursuant to subdivision 3 or 4, the meeting must be scheduled to take place at least seven days before a notice of termination is issued. The facility must make reasonable efforts to ensure that the resident, legal representative, and designated representative are able to attend the meeting. (c) For a termination pursuant to subdivision 5, the meeting must be scheduled to take place at least five days before a notice of termination is issued. The facility must make reasonable efforts to ensure that the resident, legal representative, and designated representative are able to attend the meeting. (d) The facility must notify the resident that the resident may invite family members, relevant health professionals, a representative of the Office of Ombudsman for Long-Term Care, a representative of the Office of Ombudsman for Mental Health and Developmental Disabilities, or	0 990			

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0 990	Continued From page 23 other persons of the resident's choosing to participate in the meeting. For residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the facility must notify the resident's case manager of the meeting. (e)In the event of an emergency relocation under subdivision 9, where the facility intends to issue a notice of termination and an in-person meeting is impractical or impossible, the facility must use telephone, video, or other electronic means to conduct and participate in the meeting required under this subdivision and rules within Minnesota Rules, chapter 4659. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct a prerequisite to termination of contract meeting with the resident and the resident's representative prior to contract termination notification of one of one resident (R4). 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: R4 was admitted to the licensee on January 12, 2023, with diagnoses of paraplegia, diabetes	0 990			

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0 990	Continued From page 24 mellitus type 2 with polyneuropathy, chronic kidney disease, and anxiety disorder. R4's Resident Profile dated and signed May 30, 2025, indicated R4 received services to include bathing assistance, compression stockings, cleaning, dressing, incontinence care, laundry, behavior management, meal assistance, repositioning, range of motion, record vitals, blood glucose, output, and bowel movements, safety check, skin care, socialization, straight catheter reminder, wound care, and transfer assistance. R4's Notice of Termination of Assisted Living Contract dated August 6, 2025, indicated the licensee terminated services effective immediately due to unable to meet the current medical needs. R4's record lacked documentation a prerequisite to termination of contract meeting was held with the resident and the resident's representative at least seven days prior to issuance of a notice or termination. On August 27, 2025, at 12:45 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she did not complete a pretermination meeting with R4 before sending the contract termination notification. The licensee's Discharge and Transfer of Residents policy dated November 1, 2022, indicated prior to issuing a notice of termination, the licensee shall schedule and participate in a pretermination meeting with the resident, the resident's legal representative and the resident's designated representative to discuss the reason	0 990			

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0 990	Continued From page 25 (s) for the proposed termination and identify/offer reasonable accommodations, modifications, or other alternatives to avoid the termination. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 990			
01050 SS=D	144G.52 Subd. 8 Content of notice of termination The notice required under subdivision 7 must contain, at a minimum: (1) the effective date of the termination of the assisted living contract; (2) a detailed explanation of the basis for the termination, including the clinical or other supporting rationale; (3) a detailed explanation of the conditions under which a new or amended contract may be executed; (4) a statement that the resident has the right to appeal the termination by requesting a hearing, and information concerning the time frame within which the request must be submitted and the contact information for the agency to which the request must be submitted; (5) a statement that the facility must participate in a coordinated move to another provider or caregiver, as required under section 144G.55; (6) the name and contact information of the person employed by the facility with whom the resident may discuss the notice of termination; (7) information on how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities to request an advocate to assist regarding the termination; (8) information on how to contact the Senior	01050			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39302	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/29/2025
NAME OF PROVIDER OR SUPPLIER MOUNT ZION CARE SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3751 RIDGE AVENUE ANOKA, MN 55303		
(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
01050	Continued From page 26 LinkAge Line under section 256.975, subdivision 7, or the Disability Hub under section 256.01, subdivision 24, and an explanation that the Senior LinkAge Line and the Disability Hub may provide information about other available housing or service options; and (9) if the termination is only for services, a statement that the resident may remain in the facility and may secure any necessary services from another provider of the resident's choosing. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to provide a termination notice which contained all required information for one of one resident (R4) 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: R4 was admitted to the licensee on January 12, 2023, with diagnoses of paraplegia, diabetes mellitus type 2 with polyneuropathy, chronic kidney disease, and anxiety disorder. R4's medical record notes recorded by licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A on July 20, 2025, at 12:48 p.m.,	01050			

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01050	Continued From page 27 indicated R4 was sent to the ER around 11:45 p.m., after several changes in condition were observed. A note recorded by LALD/CNS-A on July 24, 2025, at 5:46 p.m., indicated an emergency relocation notification was created. A note recorded by LALD/CNS-A on July 29, 2025, indicated the emergency relocation notification was sent to the hospital social worker for R4, R4's case manager, and the Office of Ombudsman. R4's medical record notes recorded by unlicensed personnel (ULP)-F on August 6, 2025, at 3:00 p.m., indicated R4 was at the facility to collect some of her items and get her checkbook but was unable to find it and got into an verbal argument with another resident she had accused of stealing it, that resident gave her some cash, and R4 left in a cab at 3:15 p.m. R4's medical record notes recorded by LALD/CNS-A on August 6, 2025, at 3:15 p.m., indicated R4 was given a 30 day notice terminating her contract and a copy of the notification was sent to the social worker at the current facility R4 is at, R4's case manager supervisor, and the Office of Ombudsman for Long Term Care (OOLTC) facilities. On August 26, 2025, the surveyor received an email from Regional Ombudsman for Long Term Care (ROLTC)-G which indicated R4 was denied readmittance after a hospitalization and did not follow the state guidelines regarding termination and included a copy of the termination notification they received from the licensee. The termination notification indicated the termination of the contract was effective August 6, 2025.	01050			

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01050	Continued From page 28 R4's written notice of termination included the required information: - the effective date of the termination of the assisted living contract; - a detailed explanation of the basis for the termination, including the clinical or other supporting rationale; - a statement that the resident has the right to appeal the termination by requesting a hearing, and information concerning the time frame within which the request must be submitted and the contact information for the agency to which the request must be submitted; and - the name and contact information of the person employed by the facility with whom the resident may discuss the notice of termination. R4's written notice of termination lacked the required information: - a detailed explanation of the conditions under which a new or amended contract may be executed; - a statement that the facility must participate in a coordinated move to another provider or caregiver, as required under section 144G.55; - information on how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities to request an advocate to assist regarding the termination; - information on how to contact the Senior LinkAge Line under section 256.975, subdivision 7, and an explanation that the Senior LinkAge Line may provide information about other available housing or service options; and - if the termination is only for services, a statement that the resident may remain in the facility and may secure any necessary services from another provider of the resident's choosing.	01050			

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01050	Continued From page 29 On August 27, 2025, at 12:50 p.m., LALD/CNS-A stated she will need to look to see which specific requirements for the termination notification sent to R4 were missing and she more than likely missed some of them when completing the termination notification. The licensee's Discharge and Transfer of Residents policy, dated November 1, 2022, indicated a written notice of contract termination will be issued to the resident, the resident's legal representative and the resident's designated representative at least 30 days before the effective date of the termination. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01050			
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and	01060			

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01060	Continued From page 30 Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the Office of Long-Term Care (OOLTC) within the required time frame for one of one resident (R4) who had an emergency relocation. 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	01060			

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01060	Continued From page 31 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: R4 was admitted to the licensee on January 12, 2023, with diagnoses of paraplegia, diabetes mellitus type 2 with polyneuropathy, chronic kidney disease, and anxiety disorder. R4's medical record notes recorded by licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A on July 20, 2025, at 12:48p.m., indicated R4 was sent to the emergency room around 11:45 p.m. on July 19, 2025, after several changes in condition were observed. A note recorded by LALD/CNS-A on July 24, 2025, at 5:46 p.m., indicated an emergency relocation notification was created. A note recorded by LALD/CNS-A on July 29, 2025, indicated the emergency relocation notification was sent to the hospital social worker for R4, R4's case manager, and the Office of Ombudsman. R4's record lacked documentation licensee provided an emergency relocation written notification as required if the resident has not returned to the facility in four days to the Office of Ombudsman for Long Term Care (OOLTC). On August 27, 2025, at 12:30 p.m., LALD/CNS-A stated she agrees the emergency relocation notification to the OOLTC was not completed within the required time frame of four days.	01060			

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01060	Continued From page 32 The licensee's Discharge and Transfer of Residents policy dated November 1, 2022, indicated in the event of an emergency relocation, the facility will, as soon as possible, provide written notice of emergency relocation to the following: - the resident; - the resident's legal representative; - the resident's designated representative; - if the resident receives home and community-based services, the resident's case manager; - if the resident has been relocated and not returned to licensee withing four (4) days, the OOLTC. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;	01470			

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01470	Continued From page 33 (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.	01470			

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01470	Continued From page 34 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received orientation to assisted living facility licensing requirements and regulations prior to providing services for one of three employees (unlicensed personnel (ULP-C)). 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-C was hired March 6, 2023, to provide direct care services to residents at the assisted living facility. On August 25, 2025, at 12:00 p.m., the evaluator observed ULP-C provide medication administration to resident (R2). ULP-C's employee records lacked the following required orientation content: - overview of assisted living statutes; - reporting maltreatment of vulnerable adults or minors; - handling of residents' complaints, reporting of complaints, and where to report;	01470			

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01470	Continued From page 35 - consumer advocacy services; - review of types of assisted living services the employee will provide and provider's scope of license; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On August 28, 2025, at 2:45 p. m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she agrees ULP-C was missing some of the required orientation topics and is not sure what happened but may have missed assigning the correct classes because ULP-C is very good at completing her assigned education Licensee's Staff Orientation and Education policy dated, November 1, 2022, indicated orientation topics will include, but not be limited to the following: - overview of Minnesota Assisted Living Facility Statute 144G and Minnesota Rules Chapter 4659; - review of the employees job description and responsibilities; - introduction to and review of the organization's policies and procedures related to the provision of Assisted Living Facility services by the individual staff person; - handling of emergencies and the use of emergency services; - compliance with Minnesota's Vulnerable Adult, including requirements based on organizational policy, identification of incidents of maltreatment and that any act that constitutes maltreatment is prohibited; - the Assisted Living Facility Bill of Rights and the employee's responsibilities to ensure the	01470			

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01470	Continued From page 36 exercise and protection of those rights; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by staff; - grievance policy/process, including reports to the Office of Health Facility Complaints; - consumer advocacy services; - the types of Assisted Living Facility services the employee will be providing based on the Uniform Checklist Disclosure of Services and the organizations category of licensure; and - the organizational chart and roles of staff within the facility. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such	01500			

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01500	Continued From page 37 as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced	01500			

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01500	Continued From page 38 by: Based on observation, interview, and record review, the licensee failed to ensure employees received all required content of annual training for each 12 months of employment for three of three employees (registered nurse (RN)-B, unlicensed personnel (ULP)-C, and (ULP)-D. 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: RN-B RN-B was hired on March 6, 2023, as an RN for the facility, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. RN-B's employee record lacked evidence RN-B successfully completed annual training as required to include: - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. ULP-C ULP-C was hired March 6, 2023, to provide direct care and services to the licensee's residents at the assisted living facility.	01500			

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01500	Continued From page 39 On August 25, 2025, at 12:00 p.m., the evaluator observed ULP-C provide medication administration to resident (R2). ULP-C's employee record lacked evidence ULP-C successfully completed annual training as required to include: - effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; and - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. ULP-D ULP-D was hired October 28, 2022, to provide direct care and services to the licensee's residents at the assisted living facility. ULP-D's employee record lacked evidence ULP-D successfully completed annual training as required to include: - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. On August 28, 2025, at 2:30 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she does not have evidence that any of these employees have completed an annual review of the provider's policies and procedures and also agrees ULP-C is missing the specific dementia topic required. The licensee's Staff Orientation and Education	01500			

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NAME OF PROVIDER OR SUPPLIER MOUNT ZION CARE SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3751 RIDGE AVENUE ANOKA, MN 55303		
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01500	Continued From page 40 policy dated, November 1, 2022, indicated all staff providing Assisted Living Facility services will complete at least eight (8) hours of education for ach twelve (12) months of employment. Education topics will include, but not be limited to, the following: - reporting of maltreatment of adults; - review of Assisted Living Facility Bill of Rights and staff responsibilities related to ensuring the exercise and protection of those rights; - review of the organization's policies and procedures related to provision of Assisted Living Facility services and how to implement them; - infection control techniques used in the home; - effective approaches to use to problem solve when working with a resident's challenging behaviors and how to communicate with resident's who have dementia, Alzheimer's Disease, or related disorders; - the principals of person-centered planning and service delivery and how they apply to direct support service provided by staff. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500			
01530 SS=E	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under	01530			

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01530	Continued From page 41 paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation 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 staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure supervisors of direct-care staff had completed dementia care	01530			

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01530	Continued From page 42 training (at least eight hours within 120 working hours of the employment start date) and two hours of initial training on mental illness and de-escalation for one of one employee registered nurse (RN)-B, and two hours of annual dementia training for one of two employees (unlicensed personnel (ULP)-C). 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 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: RN-B RN-B was hired on March 6, 2023, as an RN for the facility, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. RN-B's employee record included 4 hours of initial dementia training completed and one (1) hour of initial mental illness and de-escalation training. RN-B's employee record lacked documentation of the following: - eight (8) hours of initial dementia training; - two (2) hours of initial mental illness and de-escalation training. ULP-C	01530			

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01530	Continued From page 43 ULP-C was hired March 6, 2023, to provide direct care and services to the licensee's residents at the assisted living facility. On August 25, 2025, at 12:00 p.m., the evaluator observed ULP-C provide medication administration to resident (R2). ULP-C's employee record included documentation ULP-C had completed 1.75 hours of annual dementia training. ULP-C's employee record lacked documentation ULP-C completed the following: - two (2) hours of annual dementia training. On August 28, 2025, at 2:20 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she agreed RN-B was missing the required 8 hours of initial dementia training and the required 2 hours of initial mental illness and de-escalation training. LALD/CNS-A also agreed ULP-C's employee record was missing the required 2 hours of annual dementia training. The licensee's Dementia Education policy dated, November 1, 2022, indicated supervisors of direct-care staff will have at least eight (8) hours of initial education within 120 working hours of employment start date in the following topics: - an explanation of Alzheimer's disease and other dementias; - assistance with activities of daily living; - problem solving with challenging behaviors; - communication skills; and - person-centered planning and service delivery. Direct care employees will complete at least two (2) hours of education on topics related to	01530			

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01530	Continued From page 44 dementia for each twelve (12) months of employment thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01530			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse	01620			

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01620	Continued From page 45 Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) 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. (f) 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 observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted ongoing 14-day resident reassessment for one of two residents (R2) and failed to conduct ongoing nursing assessments not to exceed 90 calendar days for three of three residents (R1, R2, and R4). 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	01620			

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01620	Continued From page 46 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted to the licensee on December 21, 2024, with diagnoses of ischemic stroke, hypertension, right hemiplegia, and chronic obstructive pulmonary disease. R2's signed Resident Profile dated March 14, 2025, indicated R2 received service to include medication administration, bathing assistance, dressing assistance, wound care, meal assistance, behavior management, toileting, transfer assistance, housekeeping, and laundry. R2's record included an admission assessment dated December 23, 2024, however, R2's 14-day assessment dated January 7, 2025, was three (3) days overdue. R2's 90-day assessment was due on or by March 21, 2025, and was completed 31days late on April 21, 2025. On August 25, 2025, at 12:00 p.m., the surveyor observed unlicensed staff (ULP)-C administer medication for R2. R1 R1 was admitted to the licensee on April 14, 2024, with diagnoses of early onset cerebellar ataxia (inability to coordinate muscle movement), essential hypertension, depressive episodes, and neuromuscular dysfunction of the bladder. R1's signed Resident Profile dated March 14, 2025, indicated R1 received services to include medication administration, bathing assistance,	01620			

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01620	Continued From page 47 dressing assistance, catheter care, incontinence care, meal assistance, behavior management, transfer assistance, housekeeping, and laundry. R1's record included 90- day nursing assessments dated October 17, 2024, December 19, 2024, March 23, 2025, and June 27, 2025. The assessment dated December 19, 2024, was four (4) days overdue. The assessment dated March 23, 2025, was four (4) days overdue. The assessment dated June 27, 2025, was six (6) days overdue. On August 25, 2025, at 12:30 p.m., the surveyor observed ULP-C assist R1 with lunch meal assistance. R4 R4 was admitted to the licensee on January 12, 2023, with diagnoses of paraplegia, diabetes mellitus type 2 with polyneuropathy, chronic kidney disease, and anxiety disorder. R4's signed Resident Profile dated May 30, 2025, indicated R4 received services to include bathing assistance, dressing assistance, straight catheter reminder, incontinence care, compression stockings, meal assistance, behavior management, wound care, repositioning, transfer assistance, housekeeping, and laundry. R4's record included 90- day nursing assessments dated January 1, 2025, April 5, 2025, and July 21, 2025. The assessment dated April 5, 2025, was four (4)days overdue. The assessment dated July 21, 2025, was 17 days overdue. August 27, 2025, at 12:20 p.m., licensed assisted	01620			

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01620	Continued From page 48 living director/clinical nurse supervisor (LALD/CNS)-A stated that she was under the impression that if the assessment was not more than a week late, it would not be an issue for survey, but did agree that all the assessments are after the required time frame. The licensee's Assessment and Reassessment policy dated November 1, 2022, indicated the registered nurse (RN) will provide a reassessment visit to update the evaluation of the resident and services no more than 14 days after initiation of services. Ongoing resident reassessments must be conducted by an RN and cannot exceed 90 days from the last date of assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620			
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided;	01650			

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01650	Continued From page 49 (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure resident service plans included all the required content for three of three residents (R1, R2, and R4). 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 the residents). The findings include: During the entrance conference on August 27, 2025, at 11:00 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A was identified responsible for the development and maintaining resident service plans.	01650			

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01650	Continued From page 50 R1 R1 was admitted to the licensee on April 14, 2024, with diagnoses of early onset cerebellar ataxia (inability to coordinate muscle movement), essential hypertension, depressive episodes, and neuromuscular dysfunction of the bladder. R1's signed Resident Profile dated March 14, 2025, indicated R1 received services to include medication administration, bathing assistance, dressing assistance, catheter care, incontinence care, meal assistance, behavior management, transfer assistance, housekeeping, and laundry. On August 25, 2025, at 12:30 p.m., the surveyor observed ULP-C assist R1 with lunch meal assistance. R2 R2 was admitted to the licensee on December 21, 2024, with diagnoses of ischemic stroke, hypertension, right hemiplegia, and chronic obstructive pulmonary disease. R2's signed Resident Profile dated March 14, 2025, indicated R2 received service to include medication administration, bathing assistance, dressing assistance, wound care, meal assistance, behavior management, toileting, transfer assistance, housekeeping, and laundry. On August 25, 2025, at 12:00 p.m., the surveyor observed unlicensed staff (ULP)-C administer medication for R2. R4 R4 was admitted to the licensee on January 12, 2023, with diagnoses of paraplegia, diabetes	01650			

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01650	Continued From page 51 mellitus type 2 with polyneuropathy, chronic kidney disease, and anxiety disorder. R4's signed Resident Profile dated May 30, 2025, indicated R4 received services to include bathing assistance, dressing assistance, straight catheter reminder, incontinence care, compression stockings, meal assistance, behavior management, wound care, repositioning, transfer assistance, housekeeping, and laundry. R1, R2, and R4's service plans lacked the following: - a description of the services to be provided the fees for the services, and the frequency of each service, according to the resident's current assessment and resident preferences -the schedule and methods of monitoring assessments of the residents -the schedule and methods of monitoring staff providing services -contingency plan that includes: - the action to be taken if the scheduled service cannot be provided - information and a method to contact the facility - the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in and emergency -the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters	01650			

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01650	Continued From page 52 On August 27, 2025, at 2:15 p.m., LALD/CNS-A stated the signed resident profile is what she has been using as the signed service plan for all the resident's and did not realize this did not meet all the requirements needed for the service plan. The licensee's Service Plans policy dated November 1, 2022, indicated the service plan includes the following: - a description of the services to be provided; the service description may be in the form of the residents care plan developed with the resident/responsible party; - the fees for services and the frequency of each service, according to the residents current review or assessment and resident preferences; - the identification of the staff or categories of staff who will provide the service; - the schedule and methods of monitoring reviews or assessments of the resident; - the schedule and method of monitoring staff providing services; - contingency plan that includes the following: - action to be taken if the scheduled service cannot be provided - information and method for a resident or resident's representative to contact the facility; - names and contact information of persons the resident wishes to have notified in an emergency - names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition; - the identification of and information on who has authority to sign for the resident in an emergency. - circumstances in which emergency medical services are not to be summoned and	01650			

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01650	Continued From page 53 declarations made by the resident related to health care directives. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650			
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document the reason why medication administration was not completed as prescribed and failed to document any follow-up procedures that were provided to meet the residents needs when medication was not administered as prescribed for two of two residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01760			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39302	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/29/2025
NAME OF PROVIDER OR SUPPLIER MOUNT ZION CARE SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3751 RIDGE AVENUE ANOKA, MN 55303			
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01760	Continued From page 54 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 the residents). The findings include: R1 R1 was admitted to the licensee on April 14, 2024, with diagnoses of early onset cerebellar ataxia (inability to coordinate muscle movement), essential hypertension, depressive episodes, and neuromuscular dysfunction of the bladder. R1's signed Resident Profile dated March 14, 2025, indicated R1 received services to include medication administration, bathing assistance, dressing assistance, catheter care, incontinence care, meal assistance, behavior management, transfer assistance, housekeeping, and laundry. On August 25, 2025, at 12:30 p.m., the surveyor observed ULP-C assist R1 with lunch meal assistance. R1's provider orders signed on February 25, 2025, indicated R2 was prescribed the following medication: - bacitracin ointment 500 grams. Apply thin layer to scratches/abrasions on back daily until area is resolved. R1's Medication Administration Records (MAR) for July 1, 2025, through August 26, 2025, indicated the following: - bacitracin medication declined 34 times out of	01760			

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01760	Continued From page 55 the 57 days; the reason listed was resolved. On August 27, 2025, at 12:25 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she reviews the MAR's daily to make sure medications are being administered properly and agreed that there should have been follow up documented to either discontinue the medication since the area resolved or get it changed to an as needed (PRN) medication for R1. R2 R2 was admitted to the licensee on December 21, 2024, with diagnoses of ischemic stroke, hypertension, right hemiplegia, and chronic obstructive pulmonary disease. R2's signed Resident Profile dated March 14, 2025, indicated R2 received service to include medication administration, bathing assistance, dressing assistance, wound care, meal assistance, behavior management, toileting, transfer assistance, housekeeping, and laundry. On August 25, 2025, at 12:00 p.m., the surveyor observed unlicensed staff (ULP)-C administer medication for R2. R2's provider orders signed on December 27, 2024, indicated R2 was prescribed the following medication: - aspirin 81 milligrams (mg) administer one tablet chewable by mouth daily; - ketoconazole 2 % shampoo apply shampoo to scalp once a week; - multivitamin 18-400 mg administer one tablet daily; - nicotine 14 mg apply one nicotine patch to	01760			

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01760	Continued From page 56 upper body or arm daily for 24 hours; - polyethylene glycol 17 grams mix each dose in liquid in the morning; and - melatonin 3mg administer one tablet by mouth at bedtime. R2's MAR for August 1, 2025, through August 28, 2025, indicated the following; - aspirin medication declined 20 of the 28 days; the reason listed was not available; - ketoconazole medication was declined four of the four days; the reason listed was declined; - multivitamin medication was declined 20 of the 28 days; the reason listed was not available; - nicotine medication was declined 24 of the 28 days; the reason listed was not available; - polyethylene glycol medication was declined 22 of the 28 days; the reason listed was declined or not needed; and - melatonin medication was declined 18 of the 27 days; the reason listed was not given or declined. On August 28, 2025, at 10:45 a.m., (LALD/CNS)-A stated R2's medications that are routinely being declined are either due to resident refusal or the insurance does not cover them and so the supply has run out and family has not provided or paid for them out of pocket. LALD/CNS-A stated she has talked to the family but has not documented this anywhere and should have followed up with the provider to advise of refusals and get changed orders if needed. The licensee's Medication Documentation policy dated November 1, 2022, indicated if the administration of one or more medications was not completed, staff will document the following: - the reason why th4e medication was not	01760			

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01760	Continued From page 57 administered; - follow up procedures to meet the resident's needs in compliance with the medication management plan; - appropriate notification to the registered nurse (RN) supervisor or other persons as instructed regarding missing doses; and - medication error report, if appropriate. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescription medications were securely locked in a substantially constructed compartments and permitted only authorized personnel to have access. 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	01880			

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01880	Continued From page 58 a large portion or all of the residents). The findings include: On August 25, 2025, at 10:25 a.m., the surveyor observed a refrigerator located in the licensee's kitchen that contained food and beverages for the residents and observed several unopened diabetic injectable medication pens that were prescribed to resident (R4). Unlicensed personnel (ULP)-C stated R4 is the only resident with refrigerated medications, she self-administers her injectable medications, and there is not a separate refrigerator for medications. ULP-C stated the temperature for the refrigerator is documented on a different shift and is unsure how to pull that report. On August 25, 2025, at 10:45 a.m., the surveyor asked ULP-C to show where the medications for resident's receiving medication administration are kept and ULP-C took the surveyor to the living room where a tall cabinet with a locking mechanism was identified as where all medications are stored. The medication cabinet was not locked, and ULP-C obtained the key for the cabinet from the top of the cabinet where other binders were also being stored. ULP-C stated she should have had the cabinet locked and the key in her pocket, but the cabinet was not locked, and the key was still on top of the cabinet where she had recently left it. R4 was admitted to the licensee on January 12, 2023, with diagnoses of paraplegia, diabetes mellitus type 2 with polyneuropathy, chronic kidney disease, and anxiety disorder. R4's signed Resident Profile dated May 30, 2025,	01880			

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01880	Continued From page 59 indicated R4 received services to include bathing assistance, dressing assistance, straight catheter reminder, incontinence care, compression stockings, meal assistance, behavior management, wound care, repositioning, transfer assistance, housekeeping, and laundry. R4's Individualized Medication Management Plan dated July 21, 2025, indicated R4 is able to administer insulin injections, staff assist in administering medication set up by the RN, R4 has a locked box for controlled substances, medications are stored in a locked medication cabinet, and R4 doesn't have access to her medications. On August 27, 2025, at 11:15 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated there is not a separate medication refrigerator but staff do record the refrigerator temperature daily and will get the temperature logs for surveyor. LALD/CNS-A stated R4 self-administers her injectable medications and stores her pens in the upper shelf of the common refrigerator door so it is in a separate area. LALD/CNS-A agreed the refrigerator where the medication pens are kept is not locked and anyone could open the refrigerator door and access the injectable medication. On August 27, 2025, at 11:20 a.m., LALD/CNS-A stated she would expect the medication cabinet to be locked at all times and if it was unlocked it would be due to staff negligence. The surveyor did not receive any refrigerator temperature logs.	01880			

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01880	Continued From page 60 The licensee's Storage/Control of Medications policy dated November 1, 2022, indicated when the licensee is providing storage of medication outside of the resident's private living space, all prescription drugs are securely locked in substantially constructed compartments according to the manufacturer's directions. Only authorized personnel have access to the stored medications. Medications requiring refrigeration are clearly labeled and stored in an enclosed container or area separated from foods. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure expired medications were disposed of for three of three residents (R1,R2 and R4). 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	01890			

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01890	Continued From page 61 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 August 25, 2025, at 10:45 a.m., the surveyor observed the medication cabinet with unlicensed personnel (ULP)-C. The cabinet contained all four resident's medications. R1's medications included bubble packs for metoprolol succinate 25 milligrams (mg), famotidine 10 mg, and loperamide 2 mg, all of which expired on August 2, 2025. R2's medications included a diclofenac 1% gel which expired in September 2024. R4's medications included loperamide 2 mg and baclofen 10 mg, both of which expired in February 2025. ULP-C confirmed the expiration dates of the medications with surveyor. On August 27, 2025, at 11:30 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she checks the medications every month for expired medications and if expired medications were found she must have missed them. The licensee's Disposition and Disposal of Medications policy dated, November 1, 2022, indicated medications for a resident who is deceased or that have been discontinued or expired may be provided for disposal and will be disposed of by a licensed nurse. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			

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01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, and names of staff and other individuals involved in the disposition for one of one discharged resident (R5). 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	01910			

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01910	Continued From page 63 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: R5 was discharged from the licensee on April 12, 2024. R5's Discharge Summary note entered on April 12, 2024, by licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A indicated R5 discharge today at about 5:20 p.m., to another facility in Coon Rapids, MN. R5 was picked up by the house manager at about 5:23 p.m. All her belongings, medications, blood sugar supplies. R5 ate dinner and 5:00 p.m., medications were administered before leaving. R5's record lacked documentation of the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, and names of staff and other individuals involved in the disposition. On August 27, 2025, at 12:30 p.m., (LALD/CNS)-A stated there was not a disposition of medications documented other than the discharge summary note and did not realize her electronic medical record system has a report to utilize for the disposition of medications and will use this report going forward. The licensee's Disposition and Disposal of Medication policy dated, November 1, 2022, indicated upon disposition, the licensee will	01910			

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01910	Continued From page 64 document the following information in the clinical record: - name, strength, and prescription number of medication, as applicable; - quantity; - method of disposition or to whom the medications were given; - date of disposition; - name(s)/signature(s) of staff or other individuals involved in disposition; and - if applicable, to whom the medications were given. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R4) with hospital-style bed rails. 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	02310			

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02310	Continued From page 65 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: On August 25, 2025, at 1:50 p.m., the surveyor observed R4's bilateral bed rails attached to the hospital bed. R4 was admitted to the licensee on January 12, 2023, with diagnoses of paraplegia, diabetes mellitus type 2 with polyneuropathy, chronic kidney disease, and anxiety disorder. R4's signed Resident Profile dated May 30, 2025, indicated R4 received services to include bathing assistance, dressing assistance, straight catheter reminder, incontinence care, compression stockings, meal assistance, behavior management, wound care, repositioning, transfer assistance, housekeeping, and laundry. R4's bed rail assessment dated July 21, 2025, included the following: - Purpose and intention of the bed rail - The resident's bed rail use/need assessment - Risk vs. benefits discussion (individualized to each resident's risks) - The resident's preferences - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements	02310			

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02310	Continued From page 66 R4's bed rail assessment dated July 21, 2025, lacked the following: - Measurements On August 27, 2025, at 12:55 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the bed rail assessment was missing the specific measurements because she missed them but will add them to the assessment today. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) last updated July 1, 2025, indicated What should be included in documentation about a resident's bed rails? One such element/performance/skill a prudent nurse performs is the documentation of all assessed data. If any aspect of patient care is not documented, it is viewed as not having been completed. Based on the above-mentioned statutes, the nurse must also abide by accepted health care standards, and the FDA requirements related to the safety of bedrails is one of those accepted standards. Best practice for documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail - Measurements - The resident's bed rail use/need assessment - Risk vs. benefits discussion (individualized to each resident's risks) - The resident's preferences - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation - Any necessary information related to interventions to mitigate safety risk or negotiated	02310			

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02310	Continued From page 67 risk agreements The licensee's Side Rail Use policy dated November 1, 2022, indicated before implementing side rails for a resident, the RN will conduct a side rail assessment that includes the following: - level of mobility, including bed mobility; - level of consciousness; - level of cognition; - presence of orthostatic hypotension; and - vision. The RN will consider the request of the resident, the resident legal representative and/or the reside designated representative request for side rails during the evaluation. The RN will discuss with the resident/representative (s) alternatives to the use of side rails. A physical therapy evaluation may be obtained, as appropriate. If the need for side rails is indicated and the resident/resident representative (s) agreed to their use, the RN will provide education related to side rails. The RN will document the purpose of the side rails and the education provided. The resident, resident's legal representative or resident's designated representative will cosign the document agreeing to the benefits and risks of the side rails. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310			



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

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Establishment Info

Mount Zion Care Services LLC
3751 Ridge Avenue
Anoka, MN 55303
Anoka County
Parcel:

Phone:

License Info

License: 0042088

Risk:
License: -1
Expires on: 12/31/2023
CFPM: Azie Khan
CFPM #: 59313; Exp: 6/10/2028

Inspection Info

Report Number: F7963251045
Inspection Type: Full - Single
Date: 8/26/2025 Time: 9:29:49 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

MET WITH PERSON ON SITE- RICHARDS KARAMAGI. MDH NURSE SURVEYOR SARABETH REMKER WAS NOT ON SITE DURING THE INSPECTION. THIS IS A RESIDENTIAL HOME WITH HOUSEHOLD REFRIGERATOR AND DISHWASHER. FINISHES INCLUDE A LAMINATE FLOOR, STONE COUNTERTOPS, LAMINATE CABINETS, PAINTED WALLS AND CEILING.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F7963251045 from 8/26/2025

Richards Karamagi
PIC


Peggy Spadafore,
Public Health Sanitarian Supervisor
651-201-3979
peggy.spadafore@state.mn.us



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Temperature Observations/Recordings

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Establishment Info	Inspection Info
Mount Zion Care Services LLC	Report Number: F7963251045
Anoka	Inspection Type: Full
County/Group: Anoka County	Date: 8/26/2025
	Time: 9:29:49 AM

Food Temperature: **Product/Item/Unit:** MILK; **Temperature Process:**

Location: at 38 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** SHRED. CHEESE; **Temperature Process:**

Location: at 38 Degrees F.

Comment:

Violation Issued?: No



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Sanitizer Observations/Recordings

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Establishment Info

Mount Zion Care Services LLC
Anoka
County/Group: Anoka County

Inspection Info

Report Number: F7963251045
Inspection Type: Full
Date: 8/26/2025
Time: 9:29:49 AM

Sanitizing Chemical: Product: Chlorine; **Sanitizing Process:**

Location: SANI BUCKET Equal To 100 PPM

Comment:

Violation Issued?: No

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:**

Location: DISHWASHER Equal To 160 Degrees F.

Comment:

Violation Issued?: No