



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONS ON PROVISIONAL LICENSE - LICENSE GRANTED

Electronic Delivery

May 2, 2025

Licensee

OZIF HEALTHCARE SERVICES LLC

4618 Drew Avenue North

Robbinsdale, MN 55422

RE: Initial License Number 413984

Health Facility Identification Number (HFID) 40286

Project Number(s) SL40286015

Dear Licensee:

On April 8, 2025, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed December 5, 2024. The follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective May 2, 2025.

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

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.

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

Sincerely,

A handwritten signature in black ink that reads 'Rick Michals'.

Rick Michals, J.D.

Executive Regional Operations Manager

**Minnesota Department of Health
Health Regulation Division**

HHH



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered

January 31, 2025

Licensee

OZIF HEALTHCARE SERVICES LLC

4618 Drew Avenue North

Robbinsdale, MN 55422

RE: Provisional Conditional License Number 413984
Health Facility Identification Number (HFID) 40286
Project Number(s) SL40286015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 5, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.16, Subd. 3(b)(2), MDH is extending the provisional license for 90-days and applying conditions necessary to bring the facility into substantial compliance. The provisional license extension and conditions are due to expire **May 1, 2025**.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state 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 for widespread violations;

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

authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is \$3,000.00. **MDH is not imposing these fines against your provisional license at this time.**

St - 0 - 0470 - 144g.41 Subdivision 1 - Minimum Requirements - \$3,000.00

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the provisional licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

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>

CONDITIONAL LICENSE ISSUED:

MDH will issue OZIF HEALTHCARE SERVICES LLC a conditional provisional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if OZIF HEALTHCARE SERVICES LLC is in substantial compliance.

The following conditions apply on the conditional provisional assisted living facility license:

- a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional provisional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the provisional license.
- b. **No new admissions:** OZIF HEALTHCARE SERVICES LLC will not admit any new residents under its conditional provisional assisted living facility license until MDH removes the “no new admissions” condition. OZIF HEALTHCARE SERVICES LLC must provide the Department:
 - i. A list of the names and birthdates of any individuals OZIF HEALTHCARE SERVICES LLC is currently in the process of admitting. These individuals will be able to continue the admittance process.
 - ii. A list of all current residents including:
 - 1. Name and birthdate of each resident
 - 2. Current payment source for services
 - 3. If Elderly Waiver, the name and contact information of the care coordinator/case manager
 - 4. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative
- c. **Consultant:** OZIF HEALTHCARE SERVICES LLC will contract with an RN to provide consultation concerning all resident(s) to whom OZIF HEALTHCARE SERVICES LLC provides provisional licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from OZIF HEALTHCARE SERVICES LLC. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant’s judgement or at the discretion of MDH. The RN must not have any affiliation with OZIF HEALTHCARE SERVICES LLC and MDH must review the RN’s credentials and approve the selection. OZIF HEALTHCARE SERVICES LLC is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to OZIF HEALTHCARE SERVICES LLC in an effort to help OZIF HEALTHCARE SERVICES LLC align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. OZIF HEALTHCARE SERVICES LLC will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements.
- d. **Reports:** The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies OZIF

HEALTHCARE SERVICES LLC and the RN consultant about a change. Each report will be electronically submitted to: Brandon Mueller, State Evaluation Team, Health Regulation Division, at brandon.w.mueller@state.mn.us and can be reached at 651-247-2064 (office) with questions about reports. The content of the reports will include information such as:

- i. Progress towards correction of orders;
 - ii. Observations of staff delivering assisted living services and the level of competency observed;
 - iii. Conversations with residents and family members about satisfaction with assisted living services;
 - iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
 - v. Overall impressions about the quality of the assisted living services delivered;
 - vi. Overall impressions about the dignity with which the residents and their family members are treated;
 - vii. Concerns; and
 - viii. Any other information requested by the Department or considered important by the RN consultant(s).
- e. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of OZIF HEALTHCARE SERVICES LLC to correct the violations cited during the survey as well as to determine the overall practice of OZIF HEALTHCARE SERVICES LLC in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive provisional licensed assisted living services. The OOLTC will share their findings with MDH.
- f. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the provisional license if MDH identifies any level 3 or 4 violations or widespread care related violations.
- g. **Corrective Action Plan:** OZIF HEALTHCARE SERVICES LLC will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
 - i. A statement of the concern
 - ii. A description of what will happen to correct the concern
 - iii. A target date for when each correction will be complete
 - iv. Who is responsible to make sure it happens
 - v. Current status of correction work
 - vi. Description of a plan to monitor and ensure ongoing substantial compliance

for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL PROVISIONAL LICENSE PERIOD:

MDH will determine if OZIF HEALTHCARE SERVICES LLC is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional provisional license period. If MDH determines OZIF HEALTHCARE SERVICES LLC is in substantial compliance on the follow up survey, MDH will remove the conditions and grant the assisted living facility license to OZIF HEALTHCARE SERVICES LLC. If MDH determines OZIF HEALTHCARE SERVICES LLC is not in substantial compliance, MDH may deny the license pursuant to Minn. Stat. § 144G.16, Subd. 3 (b) (2).

REQUEST FOR RECONSIDERATION:

Pursuant to Minn. Stat. §144G.16, Subd. 4, if a provisional licensee whose assisted living facility license has been denied, or extended with conditions, disagrees with the action taken against the provisional license under this section, the provisional licensee may request a reconsideration no later than 15 calendar days after provisional licensee receives notice of the action. **This is your only ability to request a reconsideration under this enforcement action.**

To submit a reconsideration request, please visit:

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

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 Casey DeVries directly at: 651-247-2064.

Sincerely,



Rick Michals, J.D.
Executive Regional Operations Manager

**Minnesota Department of Health
Health Regulation Division**

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40286	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER OZIF HEALTHCARE SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 4618 DREW AVENUE NORTH ROBBINSDALE, MN 55422		
(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 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: SL40286015-0 On December 2, 2024, through December 5, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were two residents, both received services under the Assisted Living Facility provisional license. An immediate correction order was identified on December 4, 2024, issued for SL40286015-0, tag identification 0470. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	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.		
0 470 SS=I	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40286	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2024
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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure they always had sufficient staffing to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis to meet the needs of one of one resident (R3), who required two-person transfers with a mechanical lift.	0 470			

Minnesota Department of Health

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0 470	Continued From page 2 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at 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: R3 was admitted to licensee for assisted living services on March 26, 2024. R3's diagnoses included type II diabetes mellitus without complication, hypertension, and history of transient ischemic attack (stroke). R3's Assessment Links to Services dated June 12, 2024, indicated R3 received the following services: mobility - needs two people to transfer, needs full help with wheelchair for mobility, diabetes management, and medication management. R3's 90-day Assessment dated November 24, 2024, indicated R3 was bed and wheelchair bound, needed help to be turned and repositioned, and always needed assist of two for all cares and for Hoyer lift transfer. The licensee's Facility Staffing Plan dated October 1, 2024, indicated staffing requirements for each shift Sunday through Saturday: day shift 7:00 a.m. - 3:00 p.m., 1.5 staff required, evening shift 3:00 p.m - 10:00 p.m., 1.5 staff required, and night shift 10:00 p.m. - 7:00 a.m., one staff required. The surveyor inquired what 1.5 staffing meant, clinical nurse supervisor (CNS)-A stated it	0 470			

Minnesota Department of Health

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0 470	Continued From page 3 meant the second staff was available for transfers but did not provide cares, that they could step out of the facility when resident was asleep or did not need the help of a second staff. The licensee's undated posted staff schedule for the day (Wednesday) indicated two staff were available for morning shift, two staff were available for evening shift, and one staff was available for night shift. On December 3, 2024, at 12:00 p.m., the surveyor requested how the resident was transferred at night and in case of emergency. CNS-A stated R3 was resistive to cares and that they rarely got out of bed. CNS-A also stated in case of emergency the staff would call paramedics, but when the surveyor asked if they would be calling paramedics for other cares, CNS-A stated they lived about 15 minutes away, and the staff could call them if they needed help. On December 4, 2024, at 11:50 a.m., unlicensed personnel (ULP)-D stated they occasionally worked night shift but R3 never requested help to get up at night. When the surveyor asked what they would do in case of an emergency, ULP-D stated they would call paramedics (911). Minnesota Administrative Rule 4659.0180, Subpart 5 dated August 11, 2021, indicated "A minimum of two direct-care staff must be scheduled and available to assist at all times whenever a resident requires the assistance of two direct-care staff for scheduled reasonably foreseeable and unscheduled needs, as reflected in the resident's assessments and service plan." The licensee's Hoyer Lift policy dated February 1, 2024, indicated [licensee] is committed to	0 470			

Minnesota Department of Health

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0 470	Continued From page 4 ensuring the safety and dignity of residents and staff when using Hoyer lifts. This policy establishes procedures for the safe and appropriate use of Hoyer lifts to prevent injuries and promote best practices in resident transfers. The policy also indicated all lifts must be performed with two staff members (2 assists) to ensure resident and staff safety, except in emergency situations where immediate action is required. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 470			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part	0 480			

Minnesota Department of Health

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0 480	Continued From page 5 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 480			

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0 480	Continued From page 6 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated December 2, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision.	0 660			

Minnesota Department of Health

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0 660	Continued From page 7 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included TB training for one of two employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's TB Risk Assessment dated October 1, 2024, indicated the facility's risk level was low. ULP-B's record lacked evidence of TB Training upon hire. On December 4, 2024, at 2:50 p.m., clinical nurse supervisor (CNS)-A stated ULP-B had been assigned all required initial training at hire in Rtask (training software), but evidently had not completed the training. The surveyor requested to know how many employees had not completed their required initial training, CNS-B stated the licensee was not sure as they were still completing their training audits.	0 660			

Minnesota Department of Health

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 660	Continued From page 8 The licensee's Tuberculosis Screening policy dated February 1, 2024, lacked verbiage for TB training requirements. 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 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	0 680			

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0 680	Continued From page 9 by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated EPP lacked evidence of the following required content: - program patient population; - process for emergency preparedness collaboration; - policies and procedures for medical documents; - emergency officials contact information; - primary/alternate means for communication; - methods for sharing information; - sharing information on occupancy/needs; and - LTC family notifications. On December 4, 2024, at 2:50 p.m., clinical nurse supervisor (CNS)-A stated the licensee thought the EPP was complete, and they would have to go through their EPP to ensure all required content was captured. The licensee's Disaster Planning and Emergency Preparedness Plan policy dated February 1, 2024, indicated the licensee would have in place	0 680			

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0 680	Continued From page 10 a written emergency and disaster plan, signage, directions, training, and drills to facilitate the management of tenant's care [residents] and services in response to a natural disaster or other emergencies. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.	0 810			

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0 810	Continued From page 11 (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 interview and record review, the licensee failed to develop a fire safety and evacuation plan with the required elements as required. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 4, 2024, at 12:00 p.m., clinical nurse supervisor (CNS)-A and unlicensed personnel/manager (ULP/M)-C provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP included the following discrepancies: - The FSEP indicated residents should be	0 810			

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0 810	Continued From page 12 evacuated to the safest exit or nearest set of smoke compartment doors away from fire and smoke. This facility was a residential home and did not contain any sort of smoke compartments or smoke compartment doors to contain fire and smoke. - The FSEP indicated when the fire alarm is triggered, all fire doors on magnetic holders will automatically close to contain smoke and fire and residents are to remain behind these doors. The facility did not have any doors that are on magnetic door holders or doors that are rated for smoke and fire. The facility also did not have a fire alarm system that supports the use of magnetic door holders. - The FSEP indicated the system was wired directly to the fire station. The facility did not have a fire alarm system that supported the direct connection to the fire station. The FSEP included standard employee procedures but 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 FSEP was provided by a third-party consultant, and it was not updated to meet the facility-specific layout. The FSEP included the RACE (Remove, Alarm, Confine and Extinguish or Evacuate) acronym as the fire safety procedure and instructed staff to pull the nearest fire alarm, clear the exit corridor, and close fire doors in case of fire, but the facility did not have a fire alarm system, fire doors. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During the interview on December 4, 2024, at	0 810			

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0 810	Continued From page 13 12:30 p.m., CNS-A stated the fire safety and evacuation plan was from a third-party provider and verified the facility needed to update the fire safety and evacuation plan, including the facility-specific fire safety protocols. CNS-A also confirmed that the facility had not developed the necessary fire protection procedures for residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a	0 950			

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0 950	Continued From page 14 designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the opportunity to identify a designated representative for one of one resident (R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R2 admitted to the licensee on May 28, 2024, and began receiving assisted living services. R2's Assisted Living Contract signed and dated May 29, 2024, lacked the opportunity to designate a representative and the verbatim "right to designate a representative for certain purposes" notice. On December 4, 2024, at 2:50 p.m., clinical nurse supervisor (CNS)-A stated the licensee was not aware of the designated representative notice and that none of the residents would have the notice in their contracts. No further information was provided.	0 950			

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0 950	Continued From page 15	0 950			
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries	01370			

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01370	Continued From page 16 between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of two employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-B started employment with the licensee on July 24, 2024, to provide direct care services to residents. ULP-B's training record lacked the following required content: COMPETENCY EVALUATIONS: - appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; (iv) dressing and assisting with toileting; and	01370			

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01370	Continued From page 17 - standby assistance techniques and how to perform them. On December 3, 2024, at 10:30 a.m., ULP-B stated they did not know what training they had received or not and that record of all the trainings completed were with the licensee's office. On December 4, 2024, at 2:55 p.m., clinical nurse supervisor (CNS)-A stated the licensee had a problem getting their staff to complete assigned training, however, when the surveyor asked about the missing competencies for ULP-B, CNS-A stated they had completed all the competencies with all the staff, and that probably they were not filed in the right place. The licensee's Competency Training Evaluations dated February 1, 2024, indicated prior to the delegation of services the registered nurse (RN) must make certain the unlicensed personnel are trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status;	01380			

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01380	Continued From page 18 (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of two employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-B started employment with the licensee on July 24, 2024, to provide direct care services to residents. ULP-B's training record lacked the following required content: COMPETENCY EVALUATIONS: - safe transfer techniques and ambulation; and	01380			

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01380	Continued From page 19 - range of motioning and positioning. On December 3, 2024, at 10:30 a.m., ULP-B stated they did not know what trainings they had received or not and that record of all the trainings completed were with the licensee's office. On December 4, 2024, at 2:55 p.m., clinical nurse supervisor (CNS)-A stated the licensee had a problem getting their staff to complete assigned training, however, when the surveyor asked about the missing competencies for ULP-B, CNS-A stated they had completed all the competencies with all the staff, and that probably they were not filed in the right place. The licensee's Competency Training Evaluations dated February 1, 2024, indicated prior to the delegation of services the registered nurse (RN) must make certain the unlicensed personnel are trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must	01530			

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01530	Continued From page 20 have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct-care staff received at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date for one of two direct care employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).	01530			

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01530	Continued From page 21 The findings include: ULP-B started employment with the licensee to provide assisted living services on May 13, 2024. ULP-B's employee record included the following dementia training topics completed on September 6, 2024, and October 18, 2024, with no number of hours of training recorded: - activities of daily living; and - dementia communication. ULP-B's record lacked eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date to include: - an explanation of Alzheimer's disease and other dementias; - problem solving with challenging behaviors; and - person-centered planning and service delivery. On December 4, 2024, at 2:50 p.m., clinical nurse supervisor (CNS)-A stated all the licensee's staff were assigned dementia topics to complete during orientation. CNS-A also stated when they realized ULP-B had not completed their dementia training they were spoken to and given time within which to complete all required dementia training. However, by the time of the survey the training was not yet completed. The licensee's Dementia Training policy dated February 1, 2024, indicated [licensee's] staff are required to complete dementia training at the time of hire and annually thereafter. The policy also indicated all the topics above would be included in the training. No further information was provided.	01530			

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01530	Continued From page 22	01530			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
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; (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 interview and record review, the licensee failed to ensure the service plan included	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40286	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER OZIF HEALTHCARE SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 4618 DREW AVENUE NORTH ROBBINSDALE, MN 55422		
(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
01650	Continued From page 23 all required content for two of two residents (R2, R3). 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 the potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted to the licensee on May 28, 2024, and began receiving assisted living services. R2's Assessment Links to Services dated May 28, 2024, indicated R2 received the following services: mobility - medication administration, blood glucose monitoring, activity assistance, bedmaking, light housekeeping, and catheter care. R3 R3 was admitted to licensee for assisted living services on March 26, 2024. R3's Assessment Links to Services dated June 12, 2024, indicated R3 received the following services: mobility - needs two people to transfer, needs full help with wheelchair for mobility, diabetes management, and medication management. R2 and R3's Assessment Links to Services (service plan) lacked the following required	01650			

Minnesota Department of Health

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01650	Continued From page 24 content: - a description of the services to be provided, 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 resident; - the schedule and methods of monitoring staff providing services; - a 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 an emergency; and - 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. On December 4, 2024, at 2:50 p.m., clinical nurse supervisor (CNS)-A stated the licensee was not aware the resident service plan was missing content. The licensee's Service Plan policy dated February 1, 2024, indicated the service plan includes the following: a. A description of the services to be provided; the service description may be in the form of the resident's care plan developed with the resident/responsible party; b. The fees for services and the frequency of	01650			

Minnesota Department of Health

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01650	Continued From page 25 each service, according to the resident's current review or assessment and resident preferences; c. The identification of the staff or categories of staff who will provide the services; d. The schedule and methods of monitoring reviews or assessments of the resident; e. The schedule and method of monitoring staff providing services; f. A contingency plan that includes the following: i. Action to be taken if the scheduled service cannot be provided; ii. Information and method for a resident or resident's representative to contact the facility; iii. 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; iv. The identification of and information as to who has the authority to sign for the resident in an emergency; and v. Circumstances in which emergency medical services are not to be summoned and declarations made by the resident related to health care directives. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility	01940			

Minnesota Department of Health

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01940	Continued From page 26 must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a current treatment or therapy management plan to include all required content for two of two residents (R2, R3) with blood glucose monitoring. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40286	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2024
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01940	Continued From page 27 or has the potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted to the licensee on May 28, 2024, and began receiving assisted living services. R2's diagnoses included Acute cystitis with hematuria, hypertension with chronic kidney failure, and type II diabetes mellitus with peripheral angiopathy without gangrene. R2's Assessment Links to Services (service plan) dated May 28, 2024, indicated R2 received the following services: medication administration, blood glucose monitoring, activity assistance, bedmaking, light housekeeping, and catheter care. R2's provider orders for blood glucose monitoring dated December 4, 2024, indicated check blood glucose twice per day. On December 3, 2024, at 8:29 a.m., the surveyor observed unlicensed personnel (ULP)-D prepare and administer insulin for R2. ULP-D stated R2's blood glucose was checked by the night staff in the morning when R2 gets up. R2's blood glucose monitoring record dated between November 3, 2024, and December 4, 2024, indicated R2's blood glucose ranges were between 83 Milligrams per deciliter (mg/dl) and 215 mg/dl. R3 R3 was admitted to licensee for assisted living	01940			

Minnesota Department of Health

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01940	Continued From page 28 services on March 26, 2024. R3's diagnoses included type II diabetes mellitus without complication, hypertension, and history of transient ischemic attack (stroke). R3's Assessment Links to Services dated June 12, 2024, indicated R3 received the following services: mobility - needs two people to transfer, needs full help with wheelchair for mobility, diabetes management, and medication management. R3's provider orders for blood glucose monitoring dated March 26, 2024, indicated check blood glucose once daily. On December 3, 2024, at 9:29 a.m., ULP-D stated R3's blood glucose check and insulin administration was completed by the night staff early in the morning. R2 and R3's record lacked a treatment or therapy management plan that included the following required content: - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions.	01940			

Minnesota Department of Health

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01940	Continued From page 29 On December 4, 2024, at 2:50 p.m., CNS-A stated they were aware of the requirement for a medication management plan. CNS-A also stated they were not aware of a treatment or therapy management plan. The licensee's Medication, Treatment and Therapy Reminders policy dated February 1, 2024, indicated residents will receive medication, treatment, and therapy reminders per RN assessment and provider orders. The policy lacked verbiage to include the content for an individualized treatment and therapy management plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			

Type: Full
Date: 12/02/24
Time: 12:30:00
Report: 1039241369

Food and Beverage Establishment Inspection Report

Page 1

Location:

OZIF HEALTHCARE SERVICES LLC
4618 DREW AVENUE NORTH
Robbinsdale, MN55422
Hennepin County, 27

Establishment Info:

ID #: 0043820
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/24

Operator:

Phone #:
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

3-501.16A2 **** Priority 1 ****

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

MILK IN REFRIGERATOR MEASURED 44 DEGREES F. THERMOSTAT ADJUSTED TO GIVE AMBIENT REFRIGERATOR TEMPERATURE OF 33 DEGREES F.

Comply By: 12/02/24

3-500D Microbial Control: disposition of food

3-501.18A **** Priority 1 ****

MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.

OPEN CONTAINER OF CHICKEN BROTH IN REFRIGERATOR HELD FOR MORE THAN 7 DAYS. FOOD DISCARDED.

Comply By: 12/02/24

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

PIC HAS TAKEN FOOD SAFETY CLASS AND STATES APPLICATION FOR CFPM FILED. INSPECTOR WILL INQUIRE WITH MDH LICENSING OFFICE. PIC. PIC STATES THEY MAY RETAKE FOOD SAFETY CLASS.

Comply By: 12/02/24

Type: Full
Date: 12/02/24
Time: 12:30:00
Report: 1039241369
OZIF HEALTHCARE SERVICES LLC

Food and Beverage Establishment Inspection Report

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.14B

MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.

WET WIPING CLOTH STORED ON EDGE OF SINK. COMPLY WITH ABOVE RULE. CLOTH SENT FOR LAUNDERING. CORRECTED ON SITE.

Comply By: 12/02/24

Surface and Equipment Sanitizers

Chlorine: = 100 PPM at Degrees Fahrenheit
Location: SANITIZER BUCKET
Violation Issued: No

Food and Equipment Temperatures

Process/Item: FREEZER
Temperature: Degrees Fahrenheit - Location: FROZEN
Violation Issued: No

Process/Item: GARAGE FREEZER
Temperature: Degrees Fahrenheit - Location: FROZEN
Violation Issued: No

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

The inspection was completed with the person in charge and reviewed with MDH nurse evaluator Benard Nyangena.

The kitchen is of residential build and should serve food for same-day service only.

The kitchen has wood cabinets with hollow base and smooth stone-like countertops, decorative tile backsplash, decorative tile floor, painted walls and ceiling. These kitchen finishes and surfaces are clean and well maintained.

The kitchen refrigerator/freezer are of residential grade.

A freezer is in-use in the garage.

A 2-compartment sink is present in kitchen. 1 compartment is designated for handwashing only.

A residential dishwashing machine is present in the kitchen. Test strips for weekly tests of dishwashing machine were presented by person-in-charge showing that dishwashing machine achieves a hot water temperature of at least 160 degrees F.

A supply of single-use gloves is present in kitchen. A food probe thermometer is on-hand.

Discussed the following with the person-in-charge: minimum cook temps for animal proteins, foodborne illness symptoms and exclusion of ill employees, avoiding bare hand contact with ready to eat foods,

Type: Full
Date: 12/02/24
Time: 12:30:00
Report: 1039241369

OZIF HEALTHCARE SERVICES LLC

Food and Beverage Establishment Inspection Report

Page 3

handwashing, sanitizing, vomit clean-up procedures, all orders on this report.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1039241369 of 12/02/24.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed: _____

Ogo Akpati
person-in-charge

Signed: _____

Aron Goodner
Public Health Sanitarian I
Freeman Building
aron.goodner@state.mn.us