Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

August 12, 2024

Licensee
Apple Group Home Inc.
1404 Kentucky Avenue South
Saint Louis Park, MN 55426

RE: License Number 417540
Health Facility Identification Number (HFID) 36035
Project Number(s) SL36035015

Dear Licensee:

On July 16, 2024, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the follow-up survey completed on March 08, 2024, and the initial survey completed on December 13, 2023. The July 16, 2024, follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective July 16, 2024.

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

Furthermore, the July 16, 2024, follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the March 08, 2024, follow-up survey.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a), state correction orders issued pursuant to the last survey completed on July 16, 2024, found not corrected at the time of the follow-up survey follow-up survey and/or subject to a penalty assessment are as follows:

0900 - Contract Required - 144g.50 Subdivision 1 - $500.00

The details of the violations noted at the time of this follow-up survey completed on July 16, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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.

Also, at the time of this follow-up survey completed on July 16, 2024, we identified the following violation(s):

1530 - Training In Dementia Care Required - 144g.64

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

DOCUMENTATION OF ACTION TO COMPLY

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's 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).

IMPOSITION OF FINES:

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.

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.

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,

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36035	A. BUILDING: _____ B. WING _____	R 07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE GROUP HOME INC	1404 KENTUCKY AVENUE SOUTH SAINT LOUIS PARK, MN 55426

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL36035015-2 On July 15, 2024, through July 16, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on March 8, 2024 At the time of the survey, there were three (3) residents; 3 receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were issued/reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	{0 480}		

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{0 480}	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required	{0 480}		
{0 650} SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by:	{0 650}		

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{0 650}	Continued From page 2 No further action required	{0 650}		
{0 900} SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the	{0 900}		

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{0 900}	Continued From page 3 licensee failed to execute a written contract prior to providing assisted living services for one of two residents (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) 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: R3 was admitted on April 15, 2021, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R3's Service Plan dated March 2024, indicated R3's services included medication management and administration. R3's record contained a blank, unsigned assisted living contract. On July 16, 2024, at approximately 12:38 p.m., director (D)-A stated all residents had a blank contract in their records as they had recently received the template from their consultant. D-A stated they had been advised by consultant not to have contracts signed until reviewed by Minnesota Department of Health surveyor. The licensee's Action Plan for Survey Results updated June 13, 2024, indicated the action item related to contracts had not yet been resolved. No further information was provided.	{0 900}		

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01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this 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 eight (8) hours of initial dementia care training and two (2) hours of dementia care training for each twelve (12) months of employment thereafter for two of two employees (owner (O)-B, unlicensed personnel (ULP)-C).	01530		

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01530	Continued From page 5 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents. The findings include: O-B was hired on July 1, 2019, under the licensee's former comprehensive license and began providing assisted living (AL) services on August 1, 2021, under the current AL license. O-B's employee record indicated O-B received one hour of dementia care education on June 18, 2024. O-B's record lacked evidence of 8 hours of initial dementia training and the required 2 hours of training on topics related to dementia for each 12 months of employment. ULP-C was hired on July 19, 2019, under the licensee's former comprehensive license and began providing AL services on August 1, 2021, under the current AL license. ULP-C's employee record indicated ULP-C received one hour of dementia care education on June 18, 2024. ULP-C's record lacked evidence of 8 hours of initial dementia training and the required 2 hours of training on topics related to dementia for each 12 months of employment. On July 16, 2024, at approximately 1:50 p.m., director (D)-A stated they didn't have dementia training and it was on her "to do" list to find a company to provide the dementia training for employees.	01530		

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01530	Continued From page 6 The licensee's Dementia Education policy dated March 11, 2024, indicated direct care staff must have completed at least 8 hours of initial dementia care training within 160 working hours of the employment start date and supervisors must have completed at least 8 hours of initial training within 120 working hours of employment start date. The policy also indicated both supervisors and direct care employees must have at least 2 hours of dementia care education for each 12 months of employment thereafter. The licensee's Action Plan for Survey Results updated on April 22, 2024, indicated sources for education had been identified and the action item was ongoing. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

April 23, 2024

Licensee
Apple Group Home Inc.
1404 Kentucky Avenue South
Saint Louis Park, MN 55426

RE: Conditional License Number 413307
Health Facility Identification Number (HFID) 36035
Project Number(s) SL36035015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a follow-up survey on March 8, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the follow-up 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.20, MDH is issuing a 90-day conditional license due to expire on **July 22, 2024**.

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.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on December 13, 2024 found not corrected at the time of the March 8, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0110 - Assisted Living Director License Required - 144g.10 Subdivision 1a
0250 - Conditions - 144g.20 Subdivision 1 - $500.00
0470 - Minimum Requirements - 144g.41 Subdivision 1 - $500.00
0485 - Minimum Requirements - 144g.41 Subdivision 1. (13)(i)(a)and(c)
0550 - Resident Grievances; Reporting Maltreatment - 144g.41 Subd. 7 - $500.00
0580 - Quality Management - 144g.42 Subd. 2 - $500.00
0640 - Posting Information For Reporting Suspected C - 144g.42 Subd. 7 - $500.00
0650 - Employee Records - 144g.42 Subd. 8- $500.00
0680 - Disaster Planning And Emergency Preparedness - 144g.42 Subd. 10 - $500.00
0810 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (b)-(f) - $500.00
0820 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (g) - $500.00
0900 - Contract Required - 144g.50 Subdivision 1 - $500.00
1440 - Supervision Of Staff Providing Delegated Nurs - 144g.62 Subd. 4 - $500.00
1460 - Orientation Of Staff And Supervisors - 144g.63 Subdivision 1 - $500.00
1620 - Initial Reviews, Assessments, And Monitoring - 144g.70 Subd. 2 (c-E) - $500.00
1650 - Service Plan, Implementation And Revisions To - 144g.70 Subd. 4 (f)
1700 - Provision Of Medication Management Services - 144g.71 Subd. 2 - $500.00
1730 - Individualized Medication Management Plan - 144g.71 Subd. 5 - $500.00

The details of the violations noted at the time of this follow-up survey completed on March 8, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on March 8, 2024, we identified the following violation(s):

0340 - Correction Orders-144g.30 Subd. 5 - $500.00
0720 - Access To Records-144g.43 Subd. 2

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $8,000.00**. 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.

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

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.

CONDITIONAL LICENSE ISSUED:
MDH will issue Apple Group Home Inc. a conditional 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 Apple Group Home Inc. is in substantial compliance.

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

a. **Health Facility Construction Permit:** Apple Group Home Inc. will contact The Minnesota Department of Labor and Industry (MNDLI) and obtain a construction permit for a health facility. Within 14-days from the date of this notice, Apple Group Home Inc. will provide MDH with a copy of the permit obtained from MNDLI.

b. **General Contractor:** Apple Group Home Inc. must provide the following information to Bob Dehler (Robert.Dehler@state.mn.us) via email within 14-Days of the date of this notice:
    a. Contractor Name
    b. License Number
    c. Contract Information

c. **Egress Window Requirements:** Apple Group Home Inc. will replace at least one window in occupied resident sleeping rooms #1, #2 and #3, meeting the minimum size requirements. At least one window in each resident bedroom must meet the minimum window opening size of no less than 20 inches in width, with a total of at least 648 square inches (4.5 square feet) required for egress, and have a windowsill height from the floor to the clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width and have a windowsill height from the floor to the clear opening of not more than 48 inches.

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:
MDH will determine if Apple Group Home Inc. is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If

MDH determines Apple Group Home Inc. is in substantial compliance on the follow up survey, MDH will remove the conditions from Apple Group Home Inc.'s assisted living facility license, and Apple Group Home Inc. will correct any outstanding violations identified during the survey. If Apple Group Home Inc. is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING A HEARING:
Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action. To submit a hearing request, please visit **https://forms.web.health.state.mn.us/form/HRD-Appeals-Form**.

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 Jess Schoenecker directly at: 651-201-3789.

Sincerely,

Rick Michals, J.D.
Interim Assistant Division Director

Minnesota Department of Health
Health Regulation Division

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36035	A. BUILDING: _____ B. WING _____	R 03/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE GROUP HOME INC	1404 KENTUCKY AVENUE SOUTH SAINT LOUIS PARK, MN 55426

(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project # SL36035015-1 On March 4, 2024, through March 8, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on December 13, 2023. At the time of the survey, there were two active residents receiving services under the Assisted Living license. As a result of the survey, the following orders were re-issued.	{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 License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance 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 surveyors' 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 subd. 1, 2, and 3.	
{0 110} SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an	{0 110}		

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{0 110}	Continued From page 1 assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director in residence (LALDIR)-E was affiliated with licensee. This had the potential to affect all the licensee's residents, staff, and visitors. 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 the potential to affect a large portion or all the residents). The findings include: On March 4, 2024, at approximately 12:04 p.m., owner (O)-B confirmed that LALDIR-E was still the LALD for the licensee. LALDIR-E obtained a residency permit on June 7, 2023. On March 4, 2024, at 12:13 p.m., the Board of Executives for Long-Term Services and Support (BELTSS) website indicated LALDIR-E held a current residency permit. The BELTSS website did not indicate LALDIR-E was affiliated with the licensee. On March 4, 2024, at approximately 1:45 p.m.,	{0 110}		

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{0 110}	Continued From page 2 surveyor spoke with LALDIR-E by phone. LALDIR-E stated they were not aware they were not affiliated with the licensee and would contact BELTSS today to have affiliation to [licensee] added to their record. On March 5, 2024, at 9:30 a.m., the BELTSS website did not indicate LALDIR-E was affiliated with the licensee. No further information provided.	{0 110}		
{0 250} SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of	{0 250}		

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{0 250}	Continued From page 3 the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the management officials who oversaw the day-to-day operations; and responsible for the resident's assisted living (AL) services, understood the assisted living facility regulations. This had the potential to affect all residents.	{0 250}		

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{0 250}	Continued From page 4 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 the residents). The findings include: The licensee's " Application for Assisted Living License," dated August 22, 2022, signed by owner (O)-B, section titled "Owner or Authorized Agent Signature of Acknowledgement", (page three (3) of the application), read, "I certify I have read and understand the following:" [a box filled in indicated completion of each of the following]: - Assisted Living Licensure statutes in Minn. Stat. chpt 144G (opens in a new window). - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659 (proposed and not final) (opens in a new window). - Reporting of Maltreatment of Vulnerable Adults (opens in a new window). - Electronic Monitoring in Certain Facilities (opens in a new window)." - "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G (opens in a new window), and Minnesota Rules, chapter 4659 (proposed and not final) (opens in a new window), governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." - "I have examined this application and all	{0 250}		

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{0 250}	Continued From page 5 attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required." - "I attest to have all required policies and procedures of Minn. Stat. chapter 144G (opens in new window). and Minn. Rules chapter 4659 (proposed and not final) (opens in new window), in place upon licensure and to keep them current as applicable." Page three (3) was electronically signed by O-B on May 13, 2022. The licensee was issued an assisted living license renewal, effective October 1, 2023. During the licensee's follow-up survey, which concluded on March 8, 2024, nineteen (19) correction orders were issued, which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. On March 4, 2024, O-B provided an Action Plan for Survey Results document and stated the action plan had been developed by their consultant. An entry on the document dated February 8, 2024, read" My overall observations are that [licensee] managerial officials did not understand the scope of the AL statute change in August 2021. They are receptive to obtaining current documents and then receiving assistance in implementing the requirements. A set of AL forms, policies, and emergency preparedness	{0 250}		

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{0 250}	Continued From page 6 manuals will be ordered. In addition, the orientation manual and competency bundle will be ordered." On March 4, 2024, an entry on the Action Plan for Survey Results document read "Has not completed most tasks. The order for the manuals was submitted Feb. 28. The manuals will be completed by the end of the week of March 18. I need to work with the director, owner, and registered nurse (RN) more specifically. Right now, none of the leadership team understand the requirements. [O-B] is working with me to accomplish this." On March 5, 2024, at 11:22 a.m., O-B stated policy manuals had been removed from the facility by their consultant and they were waiting for updated policies. No further information provided.	{0 250}		
0 340 SS=F	144G.30 Subd. 5 Correction orders a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public	0 340		

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0 340	Continued From page 7 documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide sufficient documentation with actions taken to comply with the correction orders from a survey completed December 13, 2023. The lack of action to ensure compliance with regulations had the potential to affect all residents receiving services from the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On December 13, 2023, at 3:00 p.m., the licensee was provided an exit email related to the conclusion of the licensee's provisional initial survey. The email was reviewed with assistant director (AD)-A and clinical nurse supervisor (CNS)-D and included a link hosted on the Minnesota Department of Health's website for the	0 340		

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0 340	Continued From page 8 Correction Order Documentation Guidelines. On January 26, 2024, at 4:06 p.m., the licensee received the results of the survey concluded on December 13, 2023. The longest time period for correction (the time frame the licensee must document and correct orders) was 21 days from the date the licensee received their results. This date was February 16, 2024. On March 4, 2024, at 10:00 a.m., upon the initiation of the licensee's revisit survey, owner (O)-B provided surveyor with a document titled Action Plan for Survey Results (Dec.13, 2023). The document indicated the action plan had been created on February 8, 2024. On March 4, 2024, at 10:00 a.m., O-B stated that most of the action items documented in the Action Plan for Survey Results had not yet been completed and licensee was waiting for assistance from their consultant and for updated policies and manuals to arrive. On March 4, 2024, at 1:21 p.m., O-B provided surveyor with an invoice showing an order was placed for policies and manuals on February 29, 2024. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at	{0 470}		

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{0 470}	Continued From page 9 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 observation, interview, and record review, the licensee failed to implement a staffing plan to determine staffing levels to meet the needs of all residents and failed to evaluate that plan at least twice a year. Additionally, the licensee failed to ensure the staffing plan was posted as required, potentially affecting all the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	{0 470}		

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{0 470}	Continued From page 10 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: On March 4, 2024, at approximately 12:30 p.m., surveyor observed that a daily staffing schedule was not posted in the common area. On March 4, 2024, at approximately 1:50 p.m., owner (O)-B stated all postings had been removed from the common area on advice of their consultant. On March 6, 2024, at 9:20 a.m., clinical nurse supervisor (CNS)- D stated a staffing plan had not been completed as they were waiting for updated documents from their consultant. March 5, 2024, at 11:22 a.m., O-B stated that their consultant had removed policies from the facility and updated policies had been ordered. The licensee's undated Action Plan for Survey Results indicated a staffing template had been provided to the licensee. No further information provided.	{0 470}		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according	{0 480}		

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{0 480}	Continued From page 11 to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{0 480}		
{0 485} SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee's assisted living contract required residents to pay for meals, housekeeping, and laundry services for two of two residents (R1, R3). This practice resulted in a level one violation (a	{0 485}		

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{0 485}	Continued From page 12 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: R1 R1 was admitted on May 22, 2023, and began receiving assisted living (AL) services. R1's resident record contained an unsigned and undated Residency Agreement: Tarpon Springs Assisted Living at Walton Place LLC. Page three of said agreement indicated daily meals, weekly housekeeping, and weekly laundry service were included in the basic service rate. R3 R3 was admitted on April 15, 2021, under the licensee's former comprehensive license and began receiving AL services on August 1, 2021. R3's resident record contained a Residency Agreement: Tarpon Springs Assisted Living at Walton Place LLC, dated April 15, 2021. Page 5 of said agreement indicated daily meals, weekly housekeeping, and weekly laundry services were included in the basic service agreement. On March 5, 2023, at approximately 11:00 a.m., owner (O)-B stated resident contracts had not been updated as they were waiting for a new contract template they had ordered from their consultant. No further information provided.	{0 485}		

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{0 550} SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure and contact information for the Office of Ombudsman for Long-Term Care (OOLTC) and the Office of Ombudsmen for Mental Health and Developmental Disabilities (OOMHDD). This had the potential to affect all the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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	{0 550}		

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{0 550}	Continued From page 14 the residents). The findings include: On March 4, 2024, at approximately 12:00 p.m., surveyor observed the common areas shared by residents, staff, and visitors lacked the required posting of the grievance procedure to include the name, telephone number, and e-mail contact information for the individuals who were responsible for handling resident grievances. In addition, there was no evidence of the contact information for the state and applicable regional OOLTC and OOMHDD. On March 4, 2024, at approximately 1:50 p.m., owner (O)-B stated that all postings had been removed from common areas per advice of their consultant. On March 5, 2024, at approximately 9:00 am, surveyor observed a blank Record of Complaint form, revised January 2014, posted in the common area. On March 5, 2024, at approximately 11:22 a.m., O-B stated they did not have a grievance policy as their consultant had removed all policies from the facility. O-B stated that policies would be replaced with assisted living policies. No further information provided.	{0 550}		
{0 580} SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the	{0 580}		

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{0 580}	Continued From page 15 quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program (QMP) appropriate to the size of the licensee and relevant to the type of services provided. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On March 5, 2024, at approximately 9:15 a.m., surveyor requested a quality improvement (QI) plan and meeting minutes. Owner (O)-B stated they did not have a QI plan and they were waiting for their consultant to send them the paperwork. On March 5, 2024, at approximately 11:22 am, O-B stated they did not have a QI policy as their policies had been removed from the facility by	{0 580}		

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{0 580}	Continued From page 16 their consultant and they were waiting for updated policies to arrive. The licensee's undated Action Plan for Survey Results read "Plan of correction completed today, 2/8" and "QI Meetings will start when the new documents arrive." No further information provided.	{0 580}		
{0 640} SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all residents, staff, and visitors.	{0 640}		

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{0 640}	Continued From page 17 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 March 4, 2024, at approximately 12:30 p.m., the facility's main entry area and common areas lacked the following required postings: - posting of 911emergency number in common areas and near telephones provided by the Assisted Living facility; and - posting of information and the reporting number for the MAARC to report suspected maltreatment of a vulnerable adult under section 626.557. On March 4, 2024, at 1:50 p.m., owner (O)-B stated all postings had been removed from common areas on the advice of their consultant. On March 5, 2024, at approximately 9:30 a.m., surveyor observed the MAARC phone number posted in the common area of the facility. However, the 911 emergency numbers were not observed to be posted in the common area or near the telephone in the main living room. The licensee lacked a policy related to posting of the adult abuse reporting and emergency numbers. On March 5, 2024, at approximately 1:50 p.m., O-B stated their consultant had removed all policies from the facility and updated policies had been ordered.	{0 640}		

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{0 640}	Continued From page 18 The licensee's undated Action Plan for Survey Results indicated the information had been posted and the action item related to MAARC and 911 posting had been completed. No further information was provided.	{0 640}		
{0 650} SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained documentation of at least eight (8)	{0 650}		

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{0 650}	Continued From page 19 hours of annual training for each twelve (12) months of employment and failed to document dementia care training on required topics for two of two employees (owner (O)-B, 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) and was issued at widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents. The findings include: O-B was hired on July 1, 2019, under the licensee's former comprehensive license and began providing assisted living (AL) services on August 1, 2021, under the current AL license. O-B's employee record lacked evidence of the 8-hour annual training requirement. Additionally, O-B's record lacked evidence of 8 hours of initial dementia training and two (2) hours of training on topics related to dementia for each 12 months of employment. ULP-C was hired on July 19, 2019. Under the licensee's former comprehensive license and began providing AL services on August 1, 2021, under the current AL license. ULP-C's employee record lacked evidence of the 8-hour annual training requirement. Additionally, ULP-C's record lacked evidence of 8 hours of initial dementia training and 2 hours of training on topics related to dementia for each 12 months of employment.	{0 650}		

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{0 650}	Continued From page 20 On March 6, 2024, at approximately 9:20 a.m., clinical nurse supervisor (CNS)-D stated that documentation on dementia training and annual training had not been completed and they were waiting for documents and assistance from their consultant. The licensee did not have policies on dementia training and annual training. On March 5, 2024, at 11:22 a.m., O-B stated their consultant had removed all policies from the facility and updated policies had been ordered. . The licensee's undated Action Plan for Survey Results indicated educational tracking tools would be provided in the new forms manual and an additional four (4) hours of dementia training content would be required. No further information was provided.	{0 650}		
{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	{0 680}		

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{0 680}	Continued From page 21 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 observation, interview, and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content and failed to post an emergency preparedness plan prominently. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On March 4, 2024, at approximately 12:30 p.m., the surveyor did not observe any signage or information regarding the licensee's disaster or emergency preparedness plan posted in a prominent location. On March 4, 2024, at 1:21 p.m., owner (O)-B stated all postings had been removed from common areas on the advice of their consultant.	{0 680}		

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{0 680}	Continued From page 22 O-B stated they did not have an EPP, and they were waiting to receive it from their consultant. On March 5, 2024, at approximately 9:30 a.m., surveyor observed an Emergency Preparedness Plan: Handout for Residents had been posted in the common area. The document appeared to be a template and did not provide information specific to the facility. The licensee did not have an EPP policy. On March 5, 2024, O-B stated their consultant had removed all policies from the facility and updated policies had been ordered. The licensee's undated Action Plan for Survey Results indicated an emergency preparedness manual had been ordered and "consultant to work with agency on implementation". No additional information was provided.	{0 680}		
0 720 SS=F	144G.43 Subd. 2 Access to records The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure that the appropriate rosters and records for three of three residents (R1, R2, R3) were readily available for timely	0 720		

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0 720	Continued From page 23 access to employees, vendors, and the commissioner authorized to access the records. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On March 4, 2024, at approximately 12:05 p.m., surveyor requested current resident roster, discharged resident roster and current employee list. On March 4, 2024, at approximately 12:18 p.m., owner (O)-B stated resident rosters and employee list were located on R-Task (an online medical record system) and they could not access them. On March 4, 2024, at approximately 1:20 p.m., surveyor requested records for R1, R2, and R3. O-B produced two plastic bins. One bin was labeled [R1] and one bin was labeled [R3]. O-B stated that additional resident information is in R-Task, and they were unable to retrieve the information. On March 5, 2024, at approximately 9:00 a.m., surveyor requested current and discharged resident rosters and employee list from O-B. Surveyor explained that these documents were previously provided to surveyors on Minnesota Department of Health (MDH) templates. O-B stated, "we will get those for you".	0 720		

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0 720	Continued From page 24 On March 5, 2024, at approximately 10:49 a.m., surveyor requested the most recent service plan and assessment for R1 and R3. Clinical nurse supervisor (CNS)-D stated they were unable to retrieve the information from R-Task as they were still learning how to use the system. On March 6, 2024, at approximately 7:30 a.m., surveyor requested current and discharged resident rosters and employee list. O-B stated, "we will get them for you." On March 6, 2024, at approximately 7:45 a.m., surveyor requested R2's record and R3's paper records from 2022 and 2023. O-B stated the records were in the custody of assistant director (AD)-A and would not be available to surveyor. O-B stated they were aware records were required to be readily available and they were unable to retrieve the records requested. No further information was provided.	0 720		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique	{0 810}		

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{0 810}	Continued From page 25 or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	{0 810}		

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{0 810}	Continued From page 26 The findings include: On March 06, 2024, at 12:30 p.m. survey staff toured the facility with owner (O)-B. It was observed there were no posted evacuation plans or diagrams in the facility. O-B verified this deficient finding at the time of discovery. During interview on March 06, 2024, O-B stated they were working with a consultant to improve the fire safety and evacuation plan, but it had not been completed. O-B also stated they had not completed any additional training or drills due to the policy still not being finalized. No further information was provided.	{0 810}		
{0 820} SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not	{0 820}		

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{0 820}	Continued From page 27 constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This affected all the residents in all three occupied bedrooms. 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 March 06, 2024, at 12:30 p.m., survey staff toured the facility with the owner (O)-B. During the tour, survey staff asked O-B to open the windows in occupied resident bedrooms #1 - #3 for measurement. The measurements were as follows: Occupied Sleeping Rooms: Bedroom #1: one window measuring 34 inches clear width, 18.5 inches clear height, and 629 square inches total open area. Bedroom #2: one window measuring 24 inches clear width, 16.5 inches clear height, and 396 square inches total open area. Bedroom #3: one window measuring 25 inches clear width, 19.5 inches clear height, and 488 square inches total open area per window. Sill height 56.5 inches above the finished floor. The windows in bedrooms #1, #2, and #3 did not meet the minimum requirements for opening height and did not meet the minimum	{0 820}		

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{0 820}	Continued From page 28 requirements for total openable area. Survey staff explained to O-B that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. O-B verbally confirmed the findings. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. During interview on March 06, 2024, at 1:30 p.m. O-B stated that the landlord needed more time to get the windows replaced and that the landlord was planning to replace the windows in the summer. Record review of the fire watch log indicated that the facility had an active fire watch and was completing it per their fire watch policy. No further information was provided.	{0 820}		
{0 900} SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and	{0 900}		

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{0 900}	Continued From page 29 (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute an assisted living written contract with the required content for two of two residents (R1, 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 residents. The findings include:	{0 900}		

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{0 900}	Continued From page 30 R1 R1 was admitted on May 22, 2023, and began receiving assisted living services. R1's record contained an unsigned Residency Agreement: Tarpon Springs Assisted Living at Walton Place LLC. The residency agreement contained statutory language pertaining to the state of Florida and lacked all content required per Minnesota statutes. R3 R3 was admitted on April 15, 2021, under licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R3's record contained a Residency Agreement: Tarpon Springs Assisted Living at Walton Place LLC, signed and dated April 15, 2021. The residency agreement contained statutory language pertaining to the state of Florida and lacked all content required per Minnesota statutes. On March 4, 2024, at 1:20 p.m., owner (O)-B stated they were waiting for their consultant to send an updated contract template. The licensee's undated Action Plan for Survey Results indicted a new contract template would be ordered. No further information was provided.	{0 900}		
{01440} SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs	{01440}		

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{01440}	Continued From page 31 (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure documentation of direct supervision for one of two employees (owner (O)-B). This had the potential to affect all three residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	{01440}		

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{01440}	Continued From page 32 The findings include: O-B was hired July 1, 2019, under licensee's former comprehensive license and began providing assisted living (AL) services on August 1, 2021, under the current AL license. O-B's employee record lacked documentation of direct supervision of delegated tasks within 30 days of hire or first performing the delegated task. On March 6, 2024, at 8:00 a.m. O-B was observed passing medications to R1. During an interview on March 6, 2024, at 9:20 a.m., clinical nurse supervisor (CND)-D stated they had not provided a 30-day supervision visit for O-B and they were waiting for additional training from their consultant. The licensee did not provide a policy for ULP supervision. On March 5, 2024, at 11:22 a.m., O-B stated the policies had been removed from the facility by their consultant and they were waiting for updated policies to arrive. No further information provided.	{01440}		
{01460} SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another	{01460}		

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{01460}	Continued From page 33 facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for two of two employees (owner (O)-B, 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 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: O-B O-B was hired July 1, 2019, under licensee's former comprehensive license and began providing assisted living (AL) services on August 1, 2021, under the current AL license. O-B's employee record lacked documentation of orientation to AL facility licensing requirements and regulations before providing AL services to residents. ULP-C ULP-C was hired on July 19, 2019, under licensee's former comprehensive license and began providing AL services on August 1, 2021, under current AL license.	{01460}		

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{01460}	Continued From page 34 ULP-C's employee record lacked documentation of orientation to AL facility licensing requirements and regulations before providing AL services to residents. On March 5, 2024, at 9:20 a.m., clinical nurse supervisor (CNS)-D stated that orientation had not been completed and they were waiting for training from their consultant. The licensee lacked a policy related to orientation. On March 5, 2024, at 11:20 a.m., O-B stated the consultant had removed all policies from the facility and they were waiting on updated policies. The licensee's undated Action Plan for Survey Results indicated an orientation manual had been ordered and all staff will complete orientation to AL when the manual has been received. No further information was provided.	{01460}		
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be	{01620}		

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{01620}	Continued From page 35 completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment to include all areas required on the uniform assessment tool and failed to ensure the comprehensive nursing assessments were completed within the required 90-day timeframe for two of two residents (R1, 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 represents a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 R1 was admitted on May 22, 2023, and began receiving assisted living (AL) services.	{01620}		

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{01620}	Continued From page 36 R1's paper record contained two Nurse Reassessment Visit forms, dated May 22, 2023, and August 25, 2023. The single page forms lacked the following content required on the uniform assessment tool: -activities of daily living; -instrumental activities of daily living; -emotional and mental health conditions; -cognition; -communication and sensory capabilities; -nutritional and hydration status; -risk indicators; and -who has decision making authority for the resident. R1's electronic record contained an Individual Review dated March 6, 2024, which clinical nurse supervisor (CNS)-D authenticated while surveyor was observing. The Individual Review was completed though R-Task and lacked the following content required on the uniform assessment tool: -physical health status; -emotional and mental health conditions; -cognition; -communication and sensory capabilities; -pain; -skin conditions; -nursing needs; -risk factors; and -who has decision making authority for treatment. R1's Nurse Reassessment Visit form dated May 22, 2023, and R1's Nurse Reassessment Visit form completed August 25, 2023, indicated a total of 95 days had passed between the assessments. Additionally, 194 days had passed between R1's Nurse Reassessment Visit form completed on August 25, 2023, and R1's Individual Review completed March 6, 2024.	{01620}		

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{01620}	Continued From page 37 R3 R3 was admitted on April 15, 2021, under the licensee's former comprehensive license and began receiving AL services on August 1, 2021. R3's paper record contained a Nurse Reassessment Visit forms dated July 17, 2021. The single page form lacked content required on the uniform assessment tool, including: -the resident's potential lifestyle preferences; -activities of daily living; -instrumental activities of daily living; -emotional and mental health conditions; -cognition; -communication and sensory capabilities; -nutritional and hydration status; -risk indicators; and -who has decision making authority for the resident. R3's paper record contained a Pre/Continues Assessments form dated October 17, 2024. The two-page form lacked content required on the uniform assessment tool including: --the resident's potential lifestyle preferences; -activities of daily living; -instrumental activities of daily living; -emotional and mental health conditions; -nutritional and hydration status; -risk indicators; and -who has decision making authority for the resident. R3's electronic record contained an Individual Review, completed in R-Task and dated March 5, 2024 (after initiation of the survey). The Individual Review lacked content required on the uniform assessment tool, including: --physical health status;	{01620}		

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{01620}	Continued From page 38 -emotional and mental health conditions; -cognition; -communication and sensory capabilities; -pain; -skin conditions; -nursing needs; and -who has decision making authority for treatment. R3's Nurse Reassessment Visit form completed on July 17, 2021, and R3's Pre/Continues Assessments form completed on October 17, 2021, indicated a total of 92 days had passed between assessments. On March 6, 2024, at 7:30 a.m., owner (O)-B stated additional assessments had been completed for R3 and were not on-site and would not be available to surveyors this week. O-B stated they were unable to retrieve the records for surveyor review. On March 6, 2024, at 9:00 a.m., clinical nurse supervisor (CNS)-D stated they had entered information into R-Task and were unaware of the required elements in the uniform assessment tool. CNS-D stated they were still learning how to use R-Task system and were waiting for further instruction from their consultant. The licensee lacked a policy related to assessments. On March 5, 2024, at 11:22 a.m., O-B stated the policies had been removed from the facility by their consultant and they were waiting for updated policies. The licensee's undated Action Plan for Survey Results indicated the consultant would educate the registered nurse on assessment requirements. Additionally, the action plan indicated this had not been scheduled as of	{01620}		

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{01620}	Continued From page 39 March 4, 2024. No further information provided.	{01620}		
{01650} SS=D	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 observation, interview, and record	{01650}		

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{01650}	Continued From page 40 review, the licensee failed to ensure residents' service plans included all required content for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's Service Plan dated May 22, 2023, indicated that R1 received services for both medication reminders and medication administration. R1's Service Plan Details lacked the following required content: -fees for services provided; -frequency of each service according to the resident's current assessment and preferences; and -the identification of staff or categories of staff who will provide each service. On March 5, 2024, at approximately 9:30 a.m., surveyor observed meal preparation services being provided to R1 by owner (O)-B. On March 6, 2024, at approximately 9:20 a.m., clinical nurse supervisor (CNS)-D stated R1's service plan had not been changed to reflect current services and they were waiting further training by their consultant. The licensee lacked a policy related to service plans. On March 5, 2024, at 11:22 a.m., O-B stated their consultant had removed all policies	{01650}		

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{01650}	Continued From page 41 from the facility and they were waiting for updated policies to arrive. The licensee's undated Action Plan for Survey Results indicated the consultant would educate and a template would be provided. The action plan document also indicated that this had not been completed as of March 4, 2024. No further information provided.	{01650}		
{01700} SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse,	{01700}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36035	A. BUILDING: _____ B. WING _____	R 03/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE GROUP HOME INC	1404 KENTUCKY AVENUE SOUTH SAINT LOUIS PARK, MN 55426

(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
{01700}	Continued From page 42 theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted an individualized medication assessment with the required content for two of two residents (R1, 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 R1 was admitted on May 22, 2023, and began receiving assisted living (AL) services. R1's service plan dated May 22, 2023, indicated R1 received medication management services which included medication reminders and medication administration. R1's record lacked evidence of a medication assessment including all required elements. R3 R3 was admitted on April 15, 2021, under the licensee's former comprehensive license and began receiving AL services on August 1, 2021. R3's Service Plan dated April 15, 2021, indicated	{01700}		

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{01700}	Continued From page 43 R3 received daily medication reminders and medication set-up by the registered nurse (RN). R3's record contained a Medication Assessment dated April 6, 2021, which lacked the following required content: -identification and review of all R3's medications, including indications for medications, side effects, contraindications, adverse reactions, and actions to address these issues; and -interventions to prevent diversion of medication. On March 6, 2024, at approximately 9:30 a.m., clinical nurse supervisor (CNS)-D stated medication assessments had not been updated as they were waiting for forms and training from their consultant. The licensee lacked a policy related to medication management. On March 5, 2024, at 11:22 a.m., owner (O)-B stated the consultant had removed all policies from the facility and they were waiting for new policies to arrive. The licensee's undated Action Plan for Survey Results indicated the consultant would educate on a template and also indicated this had not been completed as of March 4, 2024. No further information was provided.	{01700}		
{01730} SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The	{01730}		

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{01730}	Continued From page 44 facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individualized	{01730}		

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{01730}	Continued From page 45 medication management plan with the required content for two of two residents (R1, 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 the residents). The findings include: R1 R1 was admitted on May 22, 2023, and began receiving assisted living (AL) services. R1's Service Plan dated May 22, 2023, indicated R1 received medication reminders and medication administration services. R1's record lacked a medication management plan including the following required elements: -a description of the storage of medications based on resident needs and preferences; -identification of persons monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; -identification of medication management tasks that may be delegated to unlicensed personnel; and -procedures for staff notifying a registered nurse or appropriate licensed health professional when problems arise with medication management. R3 R3 was admitted on April 15, 2021, under the licensee's former comprehensive license and	{01730}		

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{01730}	Continued From page 46 began receiving AL services on August 1, 2021. R3's Service Plan dated April 15, 2021, indicated R3 received daily medication reminders and medication set-up by the registered nurse (RN). R3's record lacked a medication management plan including the following required elements: -a description of the storage of medications based on resident needs and preferences; -identification of persons monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; -identification of medication management tasks that may be delegated to unlicensed personnel; and -procedures for staff notifying a registered nurse or appropriate licensed health professional when problems arise with medication management. On March 6, 2024, at approximately 9:30 a.m., clinical nurse supervisor (CNS)-D stated they had not completed or updated medication management plans and were waiting for training from their consultant. The licensee lacked a policy specific to medication management plans. On March 5, 2024, at 11:22 a.m., owner (O)-B stated the consultant had removed all policies from the facility and they were waiting for updated policies to arrive. The licensee's undated Action Plan for Survey Results indicated the consultant would educate on the medication management plan. The action plan also indicated this had not been completed as of March 2, 2024. No further information provided.	{01730}		

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Electronically Delivered

January 26, 2024

Licensee
Apple Group Home Inc
1404 Kentucky Avenue South
Saint Louis Park, MN 55426

RE: Project Number(s) SL36035015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 13, 2023, 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.

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 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of

abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. 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.

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

If you have any questions, please contact me.

Sincerely,

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36025015-0 On December 11, 2023, through December 13, 2023, the Minnesota Department of Health conducted a survey at the above licensed provider, and the following correction orders are issued. At the time of the survey, there were three active residents receiving services under the Assisted Living license. An immediate correction order was identified on December 11, 2023, issued for SL36035015-0, tag identification 0820 On December 14, 2023, the immediacy of correction order 0820 was removed, however non-compliance remained at a widespread scope and a level three violation.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance 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 surveyors' 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 pursuant to 144G.31 Subd. 1, 2 and 3	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director in residence (LALDIR)-E was affiliated with licensee. This had the potential to affect all the licensee's residents, staff, and visitors. 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 the potential to affect a large portion or all the residents). The findings include: On December 11, 2023, at approximately 12:30 p.m., LALDIR-D was identified as the LALD for licensee. LALDIR-E obtained a residency permit on June 7, 2023. On December 11, 2023, at approximately 4:18 p.m., the Board of Executives for Long-Term Services and Support (BELTSS) website indicated LALDIR-D held a current residency permit. The BELTSS website did not indicate LALDIR-E was affiliated with the licensee.	0 110		

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0 110	Continued From page 2 On December 13, 2023, at approximately 10:00 a.m., assistant director (AD)-A stated they did not know LALDIR-E was not affiliated with licensee and did not know if LALDIR-E is working with a mentor. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's	0 250		

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0 250	Continued From page 3 residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the management officials who oversaw the day-to-day operations; and responsible for the resident's assisted living services, understood all of the assisted living facility regulations. This had the potential to affect all residents. This practice resulted in a level two violation (a	0 250		

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0 250	Continued From page 4 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 the residents). The findings include: The licensee's " Application for Assisted Living License," dated August 22, 2022, signed by owner (O)-B, section titled "Owner or Authorized Agent Signature of Acknowledgement", (page three (3) of the application), read, "I certify I have read and understand the following:" [a box filled in indicated completion of each of the following]: - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G (opens in a new window). - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659 (proposed and not final) (opens in a new window). - Reporting of Maltreatment of Vulnerable Adults (opens in a new window). - Electronic Monitoring in Certain Facilities (opens in a new window)." - "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G (opens in a new window), and Minnesota Rules, chapter 4659 (proposed and not final) (opens in a new window), governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." - "I have examined this application and all attachments and checked the above boxes	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 250	Continued From page 5 indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." - "I attest to have all required policies and procedures of Minn. Stat. chapter 144G (opens in new window). and Minn. Rules chapter 4659 (proposed and not final) (opens in new window), in place upon licensure and to keep them current as applicable." Page three (3) was electronically signed by O-B on May 13, 2022. The licensee was issued an assisted living license renewal, effective August 22, 2022. During the licensee's survey which concluded on December 13, 2023, twenty-six (26) correction orders were issued, which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. On December 11, 2023, at 12:10 p.m., during the entrance conference, assistant director (AD)-A stated they understood the current minimum assisted living requirements. The licensee's policy manuals indicated that policies and procedures were purchased from a care provider group and were developed on or prior to June 2020. The licensee's policies lacked revision dates or customization to the licensee and were written as home care policies under 144A Minnesota statutes.	0 250		

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	36035	A. BUILDING: _____ B. WING _____	12/13/2023

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0 250	Continued From page 6 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for 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:	0 470		

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0 470	Continued From page 7 Based on observation and interview, the licensee failed to implement a staffing plan to determine staffing levels to meet the needs of all residents and failed to evaluate that plan at least twice a year. Additionally, the licensee failed to ensure the staffing plan was posted as required, potentially affecting all the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On December 11, 2023, at 12:30 p.m., assistant director (AD)-A stated there was not a staffing plan and "the owner is the one who decides on staff". On December 11, 2023, at approximately 1:30 p.m., the surveyor did not observe a posted staff schedule during a tour of the facility. AD-A stated they were not aware a staffing schedule had to be posted in a common area for residents, staff, and visitors to be able to access. On December 12, 2023, at 11:00 a.m., AD-A posted an undated staff schedule in common dining room. AD-A stated the schedule was undated as it did not change week to week. No further information provided.	0 470		

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0 470	Continued From page 8 TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports dated December 11, 2023. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		

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0 485	Continued From page 9	0 485		
0 485 SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee's assisted living contract required residents to pay for meals, housekeeping, and laundry services. This had the potential to affect all residents. 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).	0 485		

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0 485	Continued From page 10 The findings include: R1 was admitted on May 22, 2023. R1's resident file contained an unsigned and undated Residency Agreement: Tarpon Springs Assisted Living at Walton Place LLC. Page three of said agreement indicated daily meals, weekly housekeeping, and weekly laundry service were included in the basic service rate. On December 11, 2023, at 11:00 a.m., assistant director (AD)-A stated that the Residency Agreement: Tarpon Springs Assisted Living at Walton Place LLC was the contract used for all residents. On December 12, 2023, at 9:45 a.m., AD-A provided surveyor with Assisted Living Contract for Housing Services document signed and dated May 22, 2023. AD-A stated the Assisted Living Contract for Housing Services document was the updated contract for R1. Page three of the document read "three well balanced meals will be provided each day, along with two snacks." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 510 SS=F	144G.41 Subd. 3 Infection control program (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	0 510		

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0 510	Continued From page 11 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 establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control. The deficient practice had the potential to affect residents, employees, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 12, 2023, at approximately 7:07 a.m., owner (O)-B donned (applied) gloves and retrieved R1's medication from closet. O-B prepared and administered medication to R1 then went downstairs and started computer. O-B then returned to kitchen and removed gloves. No hand hygiene observed. On December 12, 2023, at approximately 8:30 a.m., observed O-B wash hands in kitchen sink	0 510		

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0 510	Continued From page 12 prior to donning gloves. O-B prepared and administered medications to R1 then went downstairs to computer. O-B removed and disposed of gloves in trash at computer station. No hand hygiene observed. On December 13, 2023, at approximately 10:30 a.m., assistant director (AD)-A provided surveyor with an infection control policy and stated the licensee did not have an infection control plan. The licensee's 1.06 Infection Control Policy dated June 20, 2020, read "proper handwashing technique is the number one step you can take to prevent the spread of infection" and indicated handwashing should be completed: -before, during, and after preparing food -before eating food -before and after caring for someone who is sick -before and after treating a cut or wound-after using the toilet -after changing diapers or cleaning up after someone who has used the toilet -after blowing your nose, coughing, or sneezing -after touching an animal or animal waste -after handling pet food or pet treats -after touching garbage. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and	0 550		

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0 550	Continued From page 13 email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure and contact information for the Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities. This had the potential to affect all the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During a facility tour on December 11, 2023, at approximately 12:30 p.m., the common areas shared by residents, staff, and visitors lacked the	0 550		

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0 550	Continued From page 14 required posting of the grievance procedure to include the name, telephone number, and e-mail contact information for the individuals who were responsible for handling resident grievances. In addition, there was no evidence of the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. On December 11, 2023, at approximately 1:45 p.m., assistant director (AD)-A acknowledged the required content was not posted in the common areas. AD-A stated they did not know that posting the grievance procedure and Ombudsman information was required. The licensee did not have a policy addressing the posting, process, or management of resident grievances. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to display the current assisted living license at the main entrance of the assisted living building.	0 570		

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0 570	Continued From page 15 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: On December 11, 2023, at approximately 12:30 p.m., the surveyor did not observe a current license posted at the licensee's main entrance during a tour of the facility. On December 11, 2023, at approximately 1:45 p.m., assistant director (AD)-A stated they were not aware a current assisted living license was required to be posted at the main entrance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about	0 580		

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0 580	Continued From page 16 quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program (QMP) appropriate to the size of the licensee and relevant to the type of services provided. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On December 11, 2023, at approximately 12:30 p.m., during the entrance conference, assistant director (AD)-A stated the licensee had a QMP but was unsure specific projects or focus of quality improvement activities. On December 12, 2023, at approximately 12:50 p.m., AD-A produced an undated Quality Improvement/Performance Improvement (QAPI) template that was not detailed or specific to the care and operations of the licensee. Upon request for additional QMP plan and minutes, AD-A stated they "talk verbally and do not keep notes but will begin doing so".	0 580		

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0 580	Continued From page 17 The licensee's undated 1.26 Quality Improvement Project policy indicated the licensee will always have at least one documented quality improvement project in place and will retain records of such projects for at least two years. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all three residents, staff, and visitors.	0 640		

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0 640	Continued From page 18 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 11, 2023, at approximately 1:00 p.m., the facility's main entry area and common areas lacked the the following required postings: - posting of 911emergency number in common areas and near telephones provided by the Assisted Living facility - posting of information and the reporting number for the MAARC to report suspected maltreatment of a vulnerable adult under section 626.557. On December 11, 2023, at 1:45 p.m., assistant director (AD)-A confirmed the required content noted above had not been posted. On December 12, 2023, at 11:00 a.m., surveyor observed AD-A posting the required information in the dining area. The licensee lacked a policy related to posting of the adult abuse reporting and emergency numbers. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 640		

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0 650	Continued From page 19	0 650		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained documentation of at least eight (8) hours of annual training for each twelve (12) months of employment. Additionally, the licensee failed to document dementia care training on required topics for two of two employees (owner (O)-B, unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a	0 650		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE GROUP HOME INC	1404 KENTUCKY AVENUE SOUTH SAINT LOUIS PARK, MN 55426

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0 650	Continued From page 20 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents. The findings include: O-B was hired on July 1, 2019, under the licensee's former comprehensive license and began providing assisted living (AL) services on August 1, 2021, under the current AL license. O-B's employee record lacked evidence of the 8 hour annual training requirement. Additionally, O-B's record lacked evidence of 8 hours of initial dementia training and two (2) hours of training on topics related to dementia for each 12 months of employment. ULP-C was hired on July 19, 2019. Under the licensee's former comprehensive license and began providing AL services on August 1, 2021, under the current AL license. ULP-C's employee record lacked evidence of the 8 hour annual training requirement. Additionally, ULP-C's record lacked evidence of 8 hours of initial dementia training and 2 hours of training on topics related to dementia for each 12 months of employment. During an interview on December 13, 2023, at approximately 10:15 a.m., assistant director (AD)-A and clinical nurse specialist (CNS)-D stated that annual training had been provided but were unable to provide required documentation. AD-A acknowledged documentation of annual	0 650		

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0 650	Continued From page 21 training was not present in employee records. AD-A produced a binder labeled Dementia Training and stated employees were required to read and sign a statement indicating they had read and understood the material. AD-A was unable to provide documentation indicating employees had received dementia care training. The licensee's undated 3.08 Annual Staff Training policy read "all staff of [name of company] that provided direct home care services will complete a minimum of eight (8) hours of annual training for each twelve (12) months of employment . The licensee's undated 3.02 Alzheimer's Disease and Related Disorders: Training and Notification policy read "[name of company] provides services to clients with Alzheimer's disease or related disorders. As a result, [name of company] will provide relevant training to caregivers and share such training information with those who request it." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
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	0 660		

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0 660	Continued From page 22 include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing and screening for one of two employees (owner (O)-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: The undated Facility TB Risk Assessment form identified O-B and clinical nurse supervisor (CNS)-D as responsible for the licensee's TB prevention program. Additionally, the Facility TB Risk Assessment lacked identification of facility risk level. O-B was hired on July 1, 2019, under licensee's former comprehensive license and started providing assisted living services August 1, 2021.	0 660		

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0 660	Continued From page 23 O-B's employee record included a Baseline TB Screening Tool for Health Care Workers (HCWs) dated July 1, 2020, indicating results of two tuberculin skin tests (TST), both interpreted as negative results on July 1, 2020. On December 13, 2023, at 9:30 a.m., assistant director (AD)-A and CNS-D stated they did not understand the requirements and licensed assisted living director in residence (LALDIR)-E was responsible for the TB prevention program. LALDIR-E was unavailable for interview. Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, indicated baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease. 2. Assessing TB history; and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST (given one to three weeks apart) or single Interferon-Gamma Release Assay (IGRA), a blood test that aids in diagnosing a tuberculosis infection. The licensee's undated 6.08 Tuberculosis and Staff Screening policy indicated new staff shall have an IGRA blood test or a two-step Mantoux conducted with the results documented on the Baseline TB Screening Tool for HCWs. 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	0 680		

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0 680	Continued From page 24 (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 by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness plan with all the required content and failed to post an emergency preparedness plan prominently. This had the potential to impact all visitors, employees, and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 680		

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0 680	Continued From page 25 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On December 11, 2023, at approximately 1:00 p.m. during a tour of the facility, the surveyor did not observe any signage or information regarding the licensee's disaster or emergency preparedness plan posted in a prominent location. On December 12, 2023, at approximately 12:30 p.m., assistant director (AD)-A provided an undated Emergency Preparedness Plan (EPP) for review. AD-A stated this was the EPP for licensee. The EPP binder contained a template for EPP that provided no details or customization for the facility. The licensee's undated 7.01 Disaster Planning and emergency Preparedness Plan read "[name of company] will have in place a written plan of action to facilitate the management of clients care and services in response to a natural disaster or other emergencies that may disrupt their ability to provide care and/or services." No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment	0 790		

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0 790	Continued From page 26 (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide adequately rated (size) portable fire extinguishers and failed to maintain the fire extinguishers in accordance with MN Statute as required for the facility. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During facility tour on December 11, 2023, from 1:00 p.m. to 2:00 p.m., survey staff toured the facility with the owner (O)-B. It was observed each of the fire extinguishers provided was 1-A:10-BC rated, and the licensee did not have at	0 790		

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0 790	Continued From page 27 least one 2-A:10-B:C rated fire extinguisher as required by MN Statute 144G.45. It was also observed the pin was missing from the fire extinguisher on the first floor. O-B verified this deficient finding at the time of discovery. It was observed the portable fire extinguishers throughout the facility lacked records to show the required maintenance. The licensee lacked records to show the required annual certification and monthly visual inspections were performed on the portable fire extinguishers. Survey staff explained to O-B the portable fire extinguishers must be provided annual certification tags and also monthly visual inspection or "quick checks" of each extinguisher by their employees to ensure all portable extinguishers are readily available, fully charged, and operable at their designated location with no obvious physical damage or condition to the extinguisher that would prevent their operation when needed. O-B verified the findings and stated that they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, 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.	0 800		

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0 800	Continued From page 28 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. The licensee failed to provide fire-rated ashtrays for resident use in smoking areas. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During facility tour on December 11, 2023, from 1:00 p.m. to 2:00 p.m., survey staff toured the facility with the owner (O)-B. It was observed the small concrete patio adjacent to the main entrance was being used as a smoking area for residents. At the time of the survey, there was no fire-rated ashtray provided for resident use in the smoking area. During interview on December 11, 2023, at 2:00 p.m., assistant director (AD)-A stated residents would smoke outside on the patio, but she did not realize she had to provide an ashtray for their use. Survey staff explained to the licensee that a fire-rated ashtray should be provided for resident use and that the discarded cigarette butts were a potential fire hazard if the cigarettes were not	0 800		

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0 800	Continued From page 29 completely extinguished before discarding them. AD-A stated she understood the risks of not having a fire-rated ashtray in the smoking area and would provide one. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one	0 810		

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0 810	Continued From page 30 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 the required content and provide the required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 11, 2023, from 1:00 p.m. to 2:00 p.m., survey staff toured the facility with owner (O)-B. It was observed there were no posted evacuation plans or diagrams in the facility. O-B verified this deficient finding at the time of discovery. On December 13, 2023, assistant director (AD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN	0 810		

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0 810	Continued From page 31 The licensee's FSEP, titled "7.05 Fire" and "9.06 Fire Policy", dated July 1, 2019, failed to include the following: 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 plan included the acronym R.A.C.E. (Rescue, Alarm, Confine and Extinguish or Evacuate) but failed to include procedures for how staff are to complete each step. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. During an interview on December 13, 2023, at 1:00 p.m., AD-A stated she understood the areas of her policy that were incomplete and would work on bringing them into compliance. TRAINING Record review indicated the licensee failed to provide evacuation training to residents at least once per year. AD-A was unable to provide	0 810		

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0 810	Continued From page 32 documentation showing any training offered to residents on the fire safety and evacuation plan. Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year as evidenced by the report for the one in-person staff training on the facility-specific plan that was completed on 07/20/2019. No other documentation was provided. During an interview on December 13, 2023, at 1:00 p.m., AD-A stated she understood the areas of her training that were insufficient and would work on bringing them into compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by:	0 820		

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0 820	Continued From page 33 Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This affected all the residents in all three occupied bedrooms. 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: On December 11, 2023, at 1:30 p.m., survey staff toured the facility with the owner (O)-B. Survey staff asked O-B to open the window in occupied resident bedroom #3 for measurement. O-B opened the awning-style window and the survey staff measured the clear opening to be 19.5 inches in height and 25 inches in width with a total openable area of 488 square inches. The sill height was 56.5 inches above the finished floor. The bedroom had two awning windows of the same size. The windows did not meet the minimum requirements for sill height, and opening height and did not meet the minimum requirements for total openable area. Survey staff asked O-B to open the windows in occupied resident bedroom #2 for measurement. O-B opened the double-hung style window and the survey staff measured the clear opening to be	0 820	This immediate correction order identified on December 11, 2023, had the immediacy removed on December 12, 2023, however non-compliance remained at an scope and level of I. This was confirmed by the licensee via email and approved by evaluation supervisor.	

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0 820	Continued From page 34 16.5 inches in height and 24 inches in width with a total openable area of 396 square inches. The other window in the bedroom was an awning-style window which cannot be used as an egress window. The double-hung style window did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. Survey staff asked O-B to open the windows in occupied resident bedroom #1 for measurement. O-B opened each window and the survey staff measured the clear opening to be 18.5 inches in height and 34 inches in width with a total openable area of 629 square inches. The window did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. Survey staff explained to O-B that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. O-B verbally confirmed the findings. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. On December 11, 2023, at 2:00 p.m., survey staff explained to O-B that an immediate correction order was issued for the above finding. O-B acknowledged the above finding. No Further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 820		

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0 820	Continued From page 35 An immediate correction order was identified on December 11, 2023, issued for SL36035015-0, tag identification 0820 On December 14, 2023, the immediacy of correction order 0820 was removed, however non-compliance remained at a widespread scope and a level three violation.	0 820		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to	0 900		

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0 900	Continued From page 36 any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute an assisted living written contract with the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents. The findings include: R1 was admitted on May 22, 2023. R1's resident file contained an unsigned Residency Agreement: Tarpon Springs Assisted Living at Walton Place LLC. The residence agreement contained statutory language pertaining to the state of Florida and lacked all content required per Minnesota statutes. On December 12, 2023, at 11:00 a.m., assistant director (AD)-A stated that the Residency Agreement: Tarpon Springs Assisted Living at Walton Place LLC was the contract used for all residents. AD stated this was the contract provided to her by a consultant.	0 900		

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0 900	Continued From page 37 On December 13, 2023, at 9:45 a.m., AD-A provided surveyor with Assisted Living Contract for Housing Services signed and dated May 22, 2023. AD-A stated the Assisted Living Contract for Housing Services was the updated contract for R1. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer.	01440		

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01440	Continued From page 38 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of direct supervision for one of two staff (owner (O)-B).This had the potential to affect all three residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: O-B was hired July 1, 2019, under licensee's former comprehensive license and began providing assisted living (AL) services on August 1, 2021, under the current AL license. O-B's employee record lacked documentation of direct supervision of delegated tasks within 30 days of hire or first performing the delegated task. On December 12, 2023, at 7:00 a.m., O-B was observed passing medications to R1. O-B stated they had been trained by the nurse and that she watches them administer medications "every few months." During an interview on December 13, 2023, at 9:45 a.m., assistant director (AD)-A and clinical nurse supervisor (CNS)-D were unaware of the 30-day supervision requirement. The undated 3.07 Supervision of Unlicensed Personnel (ULP) policy read "ULP must be	01440		

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01440	Continued From page 39 supervised by an RN within 30 days after the date on which the individual begins working for the home care provider and first performs delegated tasks for clients and thereafter as needed based on performance". No further information provided. TIME PERIOD TO CORRECT: Twenty-one (21) Days	01440		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for two of two employees (owner (O)-B, 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 widespread scope (when	01460		

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01460	Continued From page 40 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: O-B was hired July 1, 2019, under licensee's former comprehensive license and began providing assisted living (AL) services on August 1, 2021, under the current AL license. O-B's employee record lacked documentation of orientation to AL facility licensing requirements and regulations before providing AL services to residents. ULP-C was hired on July 19, 2019, under licensee's former comprehensive license and began providing AL services on August 1, 2021, under current AL license. ULP-C's employee record lacked documentation of orientation to AL facility licensing requirements and regulations before providing AL services to residents. On December 13, 2021, at 10:15 a.m., assistant director (AD)-A acknowledged that documentation of orientation to AL facility licensing requirements and regulations was not present in O-B and ULP-C's employee records. AD-A stated they were not aware of orientation requirements with the change to AL licensure. The licensee did not have a policy for orientation to AL regulations or licensing requirements. No further information was provided. TIME PERIOD FOR CORRECTION:	01460		

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01460	Continued From page 41 Twenty-One (21) days	01460		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment to include all areas required on the uniform assessment tool and failed to ensure the comprehensive nursing assessments were completed within the required 90-day timeframe	01620		

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01620	Continued From page 42 for two of two residents (R1, 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represents a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 R1 was admitted on May 22, 2023. R1's record contained two Nurse Reassessment Visit forms, dated May 22, 2023, and August 25, 2023. No subsequent assessments were provided. The single page forms lacked the following content required on the uniform assessment tool: -activities of daily living; -instrumental activities of daily living; -emotional and mental health conditions; -cognition; -communication and sensory capabilities; -nutritional and hydration status; -risk indicators; and -who has decision making authority for the resident. R1s current Nurse Reassessment Visit form dated May 22, 2023, and R1's Nurse Reassessment Visit form completed August 25, 2023, indicated a total of 95 days had passed between the assessments. Additionally 108 days had passed between R1's last assessment dated August 25, 2023 and December 11, 2023 (date of	01620		

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01620	Continued From page 43 survey). R2 R2 was admitted on June 15, 2023. R2's record contained two Nurse Reassessment Visit forms dated June 15, 2023, and September 18, 2023. No additional assessments were provided. The single page forms lacked content required on the uniform assessment tool, including: -activities of daily living; -instrumental activities of daily living; -emotional and mental health conditions; -cognition; -communication and sensory capabilities; -nutritional and hydration status; -risk indicators; and -who has decision making authority for the resident. R2's current Nurse Reassessment Visit form completed on September 18, 2023, and R2's Nurse Reassessment Visit form previously completed on June 15, 2023, indicated a total of 100 days had passed between assessments. On December 13, 2023, at 10:15 a.m., clinical nurse supervisor (CNS)-D stated assessments were completed on admission, at 14 days and then every 90 days thereafter. Assistant director (AD)-A and CNS-D stated they were unaware of required assessment content and requirements would be met with the ongoing implementation of R-Task documentation system. The Minnesota Administrative Rule 4659.0150, indicated each facility must develop a uniform assessment tool to include all of the required elements.	01620		

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01620	Continued From page 44 The licensee's 4.03 undated Assessment-Schedules policy read "nurses shall conduct assessments, monitoring and reassessments consistent with comprehensive Home Care requirements and the individualized needs of each home care client" and referenced 144A Minnesota (MN) statutes. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01650 SS=D	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;	01650		

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01650	Continued From page 45 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 residents' service plans included all required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's Service Plan Detail was dated May 22, 2023. R1's Service Plan indicated that R1 received services for both medication reminders and medication administration. R1's Service Plan Details lacked the following required content: -fees for services provided; -frequency of each service according to the resident's current assessment and preferences; and -the identification of staff or categories of staff who will provide each service. On December 12, 2023, at approximately 9:30 a.m., surveyor observed housekeeping services being provided to R1 by owner (O)-B.	01650		

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01650	Continued From page 46 On December 13, 2023, at 10:15 a.m., assistant director (AD)-A and clinical curse supervisor (CNS)-D stated R1 received housekeeping and laundry services in addition to medication management and were unaware the services were not identified on R1's Service Plan. AD-A and CNS-D stated they were unaware of the required content of the service plan. The licensee's undated 4.09 Service Plans policy indicated service plans would include the following elements: -a description of the home care services to be provided, the fees for services, and the frequency of each service. -the identification of the type of staff that will provide the service. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and	01700		

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01700	Continued From page 47 identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted an individualized medication assessment with the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affectedor one or a limited number of staff are involved, or the situation has occurred only occasionallly). The findings include: R1 was admitted on May 22, 2023. R1's service plan dated May 22, 2023, indicated R1 received medication management services which included medication reminders and	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36035	A. BUILDING: _____ B. WING _____	12/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE GROUP HOME INC	1404 KENTUCKY AVENUE SOUTH SAINT LOUIS PARK, MN 55426

(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
01700	Continued From page 48 medication administration. R1's record lacked evidence of a completed medication assessment including identification and review of all R1's medications, indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. On December 13, 2023, at 10:30 a.m., CNS-D acknowledged R1's record did not contain a complete medication assessment and stated that she checks resident medications weekly when she is in the facility. The licensee's undated 5.10 Medication Management Services Provided by Unlicensed Personnel policy indicated the following: -a registered nurse (RN) must conduct a face-to-face client assessment to determine what medication management services will be provided and how those services will be provided. -the home care provider must prepare and include in the service plan a written statement of the medication management services that will be provided to the client. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management	01730		

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01730	Continued From page 49 services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01730		

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APPLE GROUP HOME INC	1404 KENTUCKY AVENUE SOUTH SAINT LOUIS PARK, MN 55426

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01730	Continued From page 50 licensee failed to develop an individualized medication management plan with the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected, or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 admitted on May 22, 2023. R1's Service Plan dated May 22, 2023, identified medication reminders and medication administration as services received. R1's record lacked a medication management plan including the following required elements: -a description of the storage of medications based on resident needs and preferences; -identification of persons monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; -identification of medication management tasks that may be delegated to unlicensed personnel; and -procedures for staff notifying a registered nurse or appropriate licensed health professional when problems arise with medication management. On December 13, 2023, at 10:15 a.m., assistant director (AD)-A and clinical nurse supervisor (CNS)-D acknowledged R1's record lacked a medication management plan and stated it would	01730		

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01730	Continued From page 51 be completed with the implementation of R-Task electronic documentation system. The licensee lacked a policy specific to medication management plans. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=D	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 ensure medication administration was documented accurately for one of one resident (R1) who received medication management. Additionally, licensee failed to ensure that medication orders were accurately documented in resident record, resulting in a transcription error.	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36035	A. BUILDING: _____ B. WING _____	12/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE GROUP HOME INC	1404 KENTUCKY AVENUE SOUTH SAINT LOUIS PARK, MN 55426

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01760	Continued From page 52 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted on May 22, 2023. R1's Service Plan dated May 22, 2023, indicated R1 received medication reminders and medication administration. On December 12, 2023, at approximately 7:00 a.m., surveyor observed owner (O)-B administer medications to R1. R1's medication packet included three (3) benztropine 0.5 milligram (mg) tablets. Following medication administration, O-B opened the R-Task electronic documentation system but failed to document medication administration. O-B stated, R-Task is a new system for medication administration and they do not fully utilize it yet and stated "I will leave it for the nurse." O-B stated that clinical nurse supervisor (CNS)-D provided staff training for medication administration. R1's record contained an E-Script New Prescription Request signed by provider on October 31, 2023, and ordered benztropine 0.5 mg tablet with directions to take three tablets by mouth twice daily. R1's Medication Administration Summary for December 2023 read "benztropine mesylate 0.5	01760		

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01760	Continued From page 53 mg. Give one tablet by mouth twice a day." On December 13, 2023, at 10:15 a.m., CNS-D stated was unaware of R1's medication transcription error and would review medications weekly. The licensee's undated 5.08 Medication Administration-Documentation policy read "documentation of a medication reminder, medication assistance, or medication administration will be completed immediately after that task has been performed." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *12/11/23*
Time: 13:55:26
Report: 8041231391

Food and Beverage Establishment Inspection Report

Location:
Apple Group Home Inc
1404 Kentucky Avenue South
St Louis Park, MN55426
Hennepin County, 27

Establishment Info:
ID #: 0038840
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6122426245
ID #:

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

The following orders were issued during this inspection.

4-700 Sanitizing Equipment and Utensils

4-702.11 ***** Priority 1 *****

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.

FACILITY IS WASHING DISHES WITH SOAP AND WATER IN ONE BASIN OF THE TWO BASIN SINK, NO SANITIZE STEP. INSTRUCTED ESTABLISHMENT TO SET UP CONTAINERS TO WASH, RINSE, SANITIZE DISHES WITH 50-100 PPM BLEACH UNTIL UNDERCOUNTER DISH MACHINE OR 3 COMP. INSTALLED

Comply By: 12/11/23

3-500C Microbial Control: date marking

3-501.17B ***** Priority 2 *****

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

OPENED PACKAGES OF MILK AND CUT MELON IN THE KITCHEN COOLER NOT DATE MARKED. DATE MARKING REQUIREMENTS REVIEWED DURING INSPECTION.

Comply By: 12/11/23

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

NO FOOD THERMOMETER ON SITE. ESTABLISHMENT COOKS THIN FOODS/MEATS.

Comply By: 12/15/23

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

NO THERMOMETER IN THE KITCHEN REFRIGERATOR.

Comply By: 12/15/23

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

SINK BASIN USED FOR HANDWASHING IN THE KITCHEN DOES NOT HAVE A HANDWASHING SIGN OR POSTER.

Comply By: 12/15/23

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: frigidair cooler: ambient air temp.
Violation Issued: No

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

Inspection was completed with the Assistant Director, Maryan Ahmed. Michelle Winters was the lead Health Regulation Division Nurse Evaluator. Kai Yang (MDH-FPLS) was also present. Facility had three residents on site at time of inspection. Meals are prepared on site.

This establishment has a residential kitchen. Food must be prepared for same day service only. The kitchen has wood cabinets with a hollow base and tile flooring. All found to be in good condition.

A two basin sink is located in the kitchen with one basin designated for handwashing.

Establishment is planning to install an under counter dish machine. Ensure it meets ANSI standard 184-residential and achieves a utensil surface temperature of at least 160F. A temperature indictor to measure the utensil surface temperature must also be provided for dish machine.

Discussed the following:
-Employee illness policy and logging requirements
-Handwashing
-Glove-use and bare hand contact
-Food storage and preventing cross contamination
-Date marking
-Vomit clean up procedures
-Restrictions concerning serving a highly susceptible population

Type: Full
Date: *12/11/23*
Time: 13:55:26
Report: 8041231391
Apple Group Home Inc

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8041231391 of 12/11/23.

Certified Food Protection Manager: Sadiyo G. Mohamed

Certification Number: fm74374 Expires: 08/20/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Nuh Ahmed
Owner

Signed: Sarah Conboy
Sarah Conboy
Public Health Sanitarian III
651-201-3984
sarah.conboy@state.mn.us