Electronically Delivered

October 24, 2024

Licensee
Applewood Home Health Care LLC
6320 Vincent Avenue South
Richfield, MN 55423

RE: Project Number(s) SL37683015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 1, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

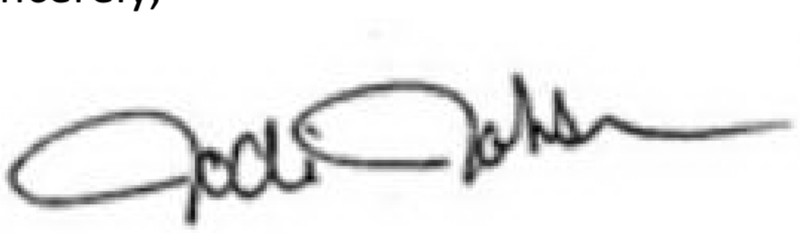
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 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
	37683	A. BUILDING: _____ B. WING _____	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLEWOOD HOME HEALTH CARE LLC	6320 VINCENT AVENUE SOUTH RICHFIELD, MN 55423

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL37683015-0 On September 30, 2024, through October 1, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were two residents; two receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 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: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 30, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements:	0 680		

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0 680	Continued From page 2 (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 interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors of the facility. 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	0 680		

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0 680	Continued From page 3 a large portion or all of the residents). The findings include: The licensee's undated, Emergency Preparedness plan was reviewed and lacked the following: Develop and maintain the EP. Maintain and annual EP updates. Process for EP collaboration. Subsistence needs for staff and patients. Procedures for tracking of staff and patients Policies and procedures for volunteers Roles under a waiver declared by the Secretary. Names and contact information for all entities providing services under an agreement. Emergency preparation training and testing. Emergency preparation training program. Emergency preparation testing requirements. On October 1, 2024, at 11:45 a.m., the surveyor reviewed Appendix Z with clinical nurse supervisor (CNS)-A and registered nurse (RN)-B. CNS-A stated the required information listed above was missing from the EP plan. The licensee's Emergency Preparedness policy dated August 1, 2024, indicated the licensee would have an identified plan in place to assure the safety and well-being of residents and staff. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	0 780		

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0 780	Continued From page 4 (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain smoke alarms and failed to provide interconnected smoke alarms throughout the facility. 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	0 780		

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0 780	Continued From page 5 or has the potential to affect a large portion or all of the residents). The findings include: During facility tour on October 1, 2024, from 10:30 a.m. through 11:06 a.m., with clinical nurse supervisor (CNS)-A, the surveyor observed the following: The smoke alarm outside resident sleeping rooms 1, 2 and 3, located on the main floor, was not working. The alarm did not function when tested and was not interconnected with other alarms in the facility. The smoke alarm located outside resident sleeping room 4, located on the main floor, was not interconnected with other alarms in the facility. The smoke alarm inside resident sleeping room 2, located on the main floor, was not working. The alarm did not function when tested and was not interconnected with other alarms in the facility. There was no smoke alarm located outside and in the immediate vicinity of resident sleeping room 6, located in the basement. The smoke alarms in the basement were not interconnected with other alarms in the facility. Smoke alarms must be provided in all sleeping rooms, and outside in the immediate vicinity of sleeping rooms. All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit.	0 780		

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0 780	Continued From page 6 During the tour CNS-A tested the smoke alarms and verified the findings. CNS-A stated they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
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 evacuation drill every other month. Evacuation of	0 810		

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0 810	Continued From page 7 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 failed to conduct the required training and drills. 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: During facility tour on October 1, 2024, from 10:30 a.m. through 11:06 a.m., with clinical nurse supervisor (CNS)-A, the surveyor observed that the evacuation maps posted throughout the facility were difficult to read. Both floors of the facility were printed on the same page, which made the print small and illegible. The maps did not show evacuation routes or exits from the facility. CNS-A stated they understood the requirement and would work to improve the maps. On October 1, 2024, at 11:10 a.m., CNS-A provided documentation on the fire safety and evacuation plan (FSEP), fire safety and	0 810		

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0 810	Continued From page 8 evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee's FSEP, titled "Fire Safety", dated August 1, 2021, failed to provide the following: 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. During an interview on October 1, 2024, at 11:25 a.m., CNS-A stated they understood the areas of the policy that were incomplete and would work on bringing them into compliance. TRAINING Record review indicated the licensee failed to provide evacuation training based on the fire safety and evacuation plan to employees, at hire and twice per year as evident by not providing documentation of training offered or training scheduled for a future date. During an interview on October 1, 2024, at 11:25 a.m., CNS-A stated they would email training records to the surveyor. No further information was provided, and no email was received. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Documentation provided showed that two evacuation drills were conducted	0 810		

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0 810	Continued From page 9 in January and July in 2024. Documentation failed to show that each shift had participated in at least two evacuation drills. During an interview on October 1, 2024, at 11:25 a.m., CNS-A stated that they understood the requirement for conduction evacuation drills. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the medication refrigerators maintained an acceptable temperature to ensure the medications were stored according to manufacturer's recommendations. 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:	01880		

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01880	Continued From page 10 On September 30, 2024, at 11:10 a.m., the surveyor toured the facility with clinical nurse supervisor (CNS)-A and registered nurse (RN)-B, including a review of the medication refrigerators. RN-B stated they had two medication refrigerators. One on the main floor in a locked hall closet. CNS-B stated the main floor refrigerator was currently empty and all refrigerated medications were stored downstairs. The downstairs medication refrigerator contained the following medication: - A box of unopened Humalog Insulin pens, a box of unopened Novolog insulin, and a box of unopened Lantus insulin pens for R3; and - An unopened box of Lispro and an unopened box of Lantus insulin for R2. The refrigerator did not contain a thermometer to monitor the temperature. The surveyor asked for the temperature log and RN-B stated they kept the logbook with the refrigerator upstairs. The refrigerator logbook contained pages of the month with daily boxes to write the refrigerator temperature: - Page July 2024, with 24 out of 31 daily temperatures recorded. - Page August 2024, with 13 out of 31 daily temperatures recorded. - Page September 2024, with all 31 dates left blank. The logbook was reviewed with CNS-A. CNS-A stated he was unaware the recordings were not being completed daily. The manufacturer's instructions for Humalog (Lispro insulin pens) last revised July 2023, indicated before opening store the insulin pens in the refrigerator (36-46 degrees F). Do not freeze	01880		

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01880	Continued From page 11 insulin and do not use if insulin has been frozen. The manufacturer's instructions for Lantus insulin pens dated December 2019, indicated before opening store the insulin pens in the refrigerator (36-46 degrees F). Do not allow the Lantus to freeze. The manufacturer's instructions for Novolog insulin pens dated June 2021, indicated before opening store the insulin pens in the refrigerator (36-46 degrees F). Do not allow the Novolog to freeze. The licensee's Storage/Control of Medications policy dated August 1, 2021, indicated medications requiring refrigeration are clearly labeled and stored in an enclosed container or area separated from foods. Temperature is maintained at 35-40 degrees. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by:	03090		

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APPLEWOOD HOME HEALTH CARE LLC	6320 VINCENT AVENUE SOUTH RICHFIELD, MN 55423

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03090	Continued From page 12 Based on observation, interview, and record review, the licensee failed to ensure signage was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all residents, staff, and visitors of the licensee. 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 September 30, 2024, at 10:30 a.m. during the entrance tour, the surveyor noted the licensee failed to post the required electronic signage at all entrances. Clinical nurse supervisor (CNS)-A stated they do not have electronic monitoring and was not aware they still had to have the electronic monitoring signage. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
6512014500

Type: Full
Date: *09/30/24*
Time: 12:30:00
Report: 1047241282

Food and Beverage Establishment Inspection Report

Location:

Applewood Home Health Care Llc
6320 Vincent Avenue South
Richfield, MN55423
Hennepin County, 27

Establishment Info:

ID #: 0039087
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5072619439
ID #:

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

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

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

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

KITCHEN REFRIGERATOR HOLDING TCS FOOD AT TEMPERATURE WARMER THAN 41F. FACILITY INSTRUCTED TO USE BASEMENT REFRIGERATOR UNTIL MAIN KITCHEN FRIDGE IS CONSISTENTLY BELOW 41F.

Comply By: 09/30/24

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

NO THERMOMETER OR THERMAL TEST STRIPS AVAILABLE ON SITE TO TEST DISHWASHER TEMPERATURE. TEST STRIPS WERE ACCIDENTALLY DISCARDED SO FACILITY WILL NEED NEW ONES.

Comply By: 10/07/24

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Food and Equipment Temperatures

Type: Full
Date: *09/30/24*
Time: 12:30:00
Report: 1047241282
Applewood Home Health Care Llc

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 44 Degrees Fahrenheit - Location: Kitchen Refrigerator- cheese
Violation Issued: Yes

Process/Item: Cold Holding
Temperature: 43 Degrees Fahrenheit - Location: Kitchen Refrigerator- milk
Violation Issued: Yes

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: Basement Refrigerator- juice
Violation Issued: No

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

The inspection was completed with the operator and reviewed with MDH Nurse Evaluator T. Fearon.

The establishment has a residential kitchen and serves food that is prepared that day. The kitchen has wood cabinets, laminate floor, tiled walls, solid counter top, and a painted ceiling.

A two basin sink is located in the kitchen. One sink basin is designated for hand washing.

A residential dish machine is located in the kitchen. Hot water sanitizing dish machine test strips were provided to test the dish machine.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, and food handling procedures

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 1047241282 of 09/30/24.

Certified Food Protection Manager Saida M Abdi

Certification Number: FM124766 Expires: 07/26/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
Rawi Dore
Operator

Signed: _____
Holly Sievers
Public Health Sanitarian 2
Metro Office
6512015946
Holly.Sievers@state.mn.us