Electronically Delivered

May 2, 2025

Licensee
Appleton Area Health
100 South Barduson Street
Appleton, MN 56208

RE: Project Number(s) SL23626015

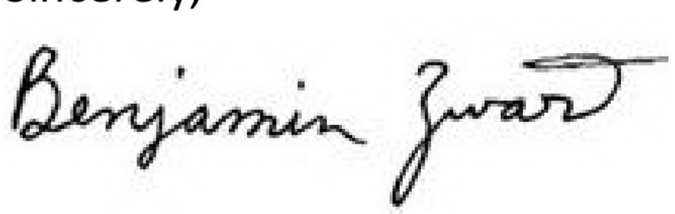
Dear Licensee:

On February 21, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on July 10, 2024. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



Benjamin J. Zwart, P.E., Supervisor
State Engineering Services Section
Health Regulation Division
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-866-890-9290

JMD

Electronically Delivered

August 5, 2024

Licensee
Appleton Area Health
100 South Barduson Street
Appleton, MN 56208

RE: Project Number(s) SL23626015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 10, 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,

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 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
	23626	A. BUILDING: _____ B. WING _____	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLETON AREA HEALTH	100 SOUTH BARDUSON STREET APPLETON, MN 56208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL23626015-0 On July 8, 2024, through, July 10, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 25 resident(s); 20 receiving services under the provider's 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.	
0 130 SS=F	144G.12, Subd. 1 Application for Licensure Each application for an assisted living facility	0 130		

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0 130	Continued From page 1 license, including provisional and renewal applications, must include information sufficient to show that the applicant meets the requirements of licensure, including: (1) the business name and legal entity name of the licensee, and the street address and mailing address of the facility; (2) the names, e-mail addresses, telephone numbers, and mailing addresses of all owners, controlling individuals, managerial officials, and the assisted living director; (3) the name and e-mail address of the managing agent and manager, if applicable; (4) the licensed resident capacity and the license category; (5) the license fee in the amount specified in section 144.122; (6) documentation of compliance with the background study requirements in section 144G.13 for the owner, controlling individuals, and managerial officials. Each application for a new license must include documentation for the applicant and for each individual with five percent or more direct or indirect ownership in the applicant; (7) evidence of workers' compensation coverage as required by sections 176.181 and 176.182; (8) documentation that the facility has liability coverage; (9) a copy of the executed lease agreement between the landlord and the licensee, if applicable; (10) a copy of the management agreement, if applicable; (11) a copy of the operations transfer agreement or similar agreement, if applicable; (12) an organizational chart that identifies all organizations and individuals with an ownership interest in the licensee of five percent or greater	0 130		

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0 130	Continued From page 2 and that specifies their relationship with the licensee and with each other; (13) whether the applicant, owner, controlling individual, managerial official, or assisted living director of the facility has ever been convicted of: (i) a crime or found civilly liable for a federal or state felony level offense that was detrimental to the best interests of the facility and its resident within the last ten years preceding submission of the license application. Offenses include: felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; any felonies involving malpractice that resulted in a conviction of criminal neglect or misconduct; and any felonies that would result in a mandatory exclusion under section 1128(a) of the Social Security Act; (ii) any misdemeanor conviction, under federal or state law, related to: the delivery of an item or service under Medicaid or a state health care program, or the abuse or neglect of a patient in connection with the delivery of a health care item or service; (iii) any misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service; (iv) any felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in Code of Federal Regulations, title 42, section 1001.101 or	0 130		

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0 130	Continued From page 3 1001.201; (v) any felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; (vi) any felony or gross misdemeanor that relates to the operation of a nursing home or assisted living facility or directly affects resident safety or care during that period; (vii) any revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority; (viii) any revocation or suspension of accreditation; or (ix) any suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or nonprocurement program; (14) whether, in the preceding three years, the applicant or any owner, controlling individual, managerial official, or assisted living director of the facility has a record of defaulting in the payment of money collected for others, including the discharge of debts through bankruptcy proceedings; (15) the signature of the owner of the licensee, or an authorized agent of the licensee; (16) identification of all states where the applicant or individual having a five percent or more ownership, currently or previously has been licensed as an owner or operator of a long-term care, community-based, or health care facility or agency where its license or federal certification has been denied, suspended, restricted, conditioned, refused, not renewed, or revoked	0 130		

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0 130	Continued From page 4 under a private or state-controlled receivership, or where these same actions are pending under the laws of any state or federal authority; (17) statistical information required by the commissioner; and (18) any other information required by the commissioner. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to meet the definition of an assisted living facility when the licensee had non-resident individuals residing at the facility. Additionally, the assisted living license effective June 1, 2024, indicated a capacity of 24 residents, however the capacity was 25, with 20 assisted living residents receiving services and 5 campus employees or contract staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: On July 8, 2024, at 12:30 p.m., during the facility tour, licensed assisted living director (LALD)-A stated there were a total of 31 apartments; 24 apartments were allocated as assisted living apartments and 7 was used for employees and contract staff. LALD-A stated she will need to look at the July 2024 apartment calendar to see how many of the apartments were currently being	0 130		

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0 130	Continued From page 5 occupied by employees or contract staff. LALD-A stated contracts were not completed with the employees or contract staff residing in the assisted living facility. The licensee's resident roster indicated 20 assisted living residents, and July 2024 apartment calendar indicated as of July 8, 2024, there was 5 campus employees currently staying at the assisted living facility. On July 10, 2024, at 11:40 p.m., LALD-A stated there was a total of 25 apartments currently occupied in the assisted living facility, and the licensee's capacity is 24. Minnesota Assisted Living Statutes 144G.08 definitions indicated: - Subd. 2. Adult - "Adult" means a natural person who has attained the age of eighteen years. - Subd. 5. Assisted living contract - "Assisted living contract" means the legal agreement between a resident and an assisted living facility for housing, and if applicable, assisted living services;" - Subd. 7. Assisted living facility - "Assisted living facility" means a facility that provides sleeping accommodations and assisted living services to one or more adults. Refer to clauses 1-15 for exclusions. - Subd. 59. Resident. - "Resident" means an adult living in an assisted living facility who has executed an assisted living contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 130		

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0 470	Continued From page 6	0 470		
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: Based on observation, interview, and record review, the licensee failed to ensure the licensee's Direct-Care Staffing Plan was evaluated at least twice a year, of the appropriateness of staffing levels in the facility. This had the potential to affect all residents, staff, and visitors.	0 470		

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0 470	Continued From page 7 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: The licensee held an assisted living license. The facility was licensed for a capacity of twenty-four and had a current census of twenty-five residents, five of those residents receiving no services. On July 8, 2024, at 10:50 a.m., during the entrance conference, licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated they did have a staffing plan but were unaware it needed to be evaluated twice a year. The licensee's Direct-Care Staffing Plan was dated November 20, 2023, but was not signed by LALD-A or CNS-B. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) 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	0 480		

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0 480	Continued From page 8 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 July 9, 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		
0 650 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	0 650		

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0 650	Continued From page 9 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 observation, interview, and record review, the licensee failed to ensure an employee record included documentation of training and competency for one of one unlicensed personnel (ULP)-D providing direct care services. 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: ULP-D was hired on April 21, 2023, to provide direct care services to residents of the assisted living facility. On July 9, 2024, at 11:34 a.m., the surveyor	0 650		

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0 650	Continued From page 10 observed ULP-D administer R1's afternoon medications. On July 9, 2024, at 11:42 a.m., ULP-D stated she was trained by the registered nurse (RN) on how to send medications out with residents. ULP-D stated there are forms to fill out and call the nurse to let her know. ULP-D stated most of the time the residents let us know a head of time and the nurse gets the medications ready. ULP-D's employee record lacked documentation of RN training and competency for medication management for residents who have unplanned time away from home. On July 10, 2024, at 12:13 p.m., clinical nurse supervisor (CNS)-B stated she has trained all staff on unplanned time away for sending medication out with residents, I just do not have it documented in staff employee records. The licensee's Assisted Living Orientation-ULP staff dated June 20, 2024, indicated the [facility] will provide the necessary medications, education, instruction and support to meet the residents medication needs when they are away from home if staff provides assistance with self-administration of medication, administration, administration or storage for medications. Only unlicensed staff that have been trained and have satisfactorily demonstrated competency will be assigned to place medications prepared by a pharmacist or a licensed nurse in a labeled envelope for an unplanned leave of absence not to exceed seven days of medication. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 650		

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0 650	Continued From page 11 (21) days	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 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 ensure its missing resident policy was reviewed at least quarterly. This had the potential to affect all residents and staff of the facility.	0 680		

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APPLETON AREA HEALTH	100 SOUTH BARDUSON STREET APPLETON, MN 56208

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0 680	Continued From page 12 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: On July 10, 2024, at 11:35 a.m., licensed assisted living director (LALD)-A stated the missing resident plan had not been reviewed quarterly. LALD-A was unaware the plan needed to be reviewed quarterly. The licensee's Missing Resident policy dated June 20, 2024, indicated the LALD and CNS will review the missing resident plan at least quarterly and document any changes to the plan. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's	0 730		

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0 730	Continued From page 13 name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation,	0 730		

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0 730	Continued From page 14 when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to complete and provide to the resident, or their representative, or case worker, a discharge summary with the required contents for one of one discharged resident (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 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: R3 was discharged from the facility on January 28, 2023. R3's diagnoses included chronic kidney disease, congestive heart failure and hypertension (high blood pressure). R3's progress note dated January 22, 2024, written by clinical nurse supervisor (CNS)-B, "A care conference was held in regard to placement for resident, [Provider name, nursing, social services] and (clinical nurse supervisor) CNS-B. Discussed concerns returning to [facility] and the recent decline in health status and that the care center would be a better option at this time. Her	0 730		

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0 730	Continued From page 15 son made the decision to place resident at the care center due to her decline in condition. She will be discharging from the hospital to the care center tomorrow due to decline in health status. She has become weaker and not able to care for herself. She had 3 falls in one week with no injury. She has had increased confusion as well." On July 10, 2024, at 11:43 a.m., CNS-B stated she could not find a discharge summary template so completed a progress note instead. CNS-B stated she was not aware of the content needed in the discharge summary. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0120, Subp. 9, effective October 2022, at the time of discharge, the facility must provide the resident, and, with the resident's consent, the resident's representatives, and case manager, with a written discharge summary that includes all content as applicable in sections A.-D. A. A summary of the residents stay that included diagnoses, courses of illnesses, allergies, treatments, and therapies, and pertinent lab, radiology, and consultation results; B. A final summary of the resident's status from the latest assessment or review under Minnesota Statutes, section 144G.70, if applicable, which included the resident status, including baseline and current mental, behavioral, and functional status; C. A reconciliation of all predischarge medications with the resident's post discharge prescribed and over-the-counter medications; and D. A post discharge care plan that was developed with the resident and, with the resident's consent, the resident's representatives, which would help the resident adjust to a new living environment. The post discharge care plan must indicate	0 730		

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0 730	Continued From page 16 where the resident planned to reside, any arrangements that had been made for the resident's follow-up care, and any post discharge medical and nonmedical services the resident would need. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to 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;	0 780		

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0 780	Continued From page 17 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms in residents sleeping room. 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). Findings include: On a facility tour on July 09, 2024, at 10:50 a.m. with environmental service manager (ESM)-K, survey staff observed that in each of the residents dwelling, they did not have a smoke alarm installed in their sleeping rooms. ESM-K verbally confirmed survey staff observations during the facility tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
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	0 800		

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0 800	Continued From page 18 residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect some of the residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On July 09, 2024, at 10:45 a.m., survey staff toured the facility with environmental service manager ESM)-K, and observed the following maintenance issues: 1. It was observed that there was a broken light cover on the second floor in the north stairwell. 2. Black dust was observed on the ceiling by the vent in the second floor hallway. 3. Mechanical room door on the second floor and all the laundry room doors were propped open. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 800		

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0 800	Continued From page 19 (21) 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 evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810		

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0 810	Continued From page 20 This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on July 09, 2024, at 11:15 p.m. with environmental service manager (ESM)-K, director of ancillary services (DAS)-J and radiology coordinator (RC)-L on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the FSEP (fire safety evacuation plan) 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, extinguish and evacuate). Also, the FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the	0 810		

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0 810	Continued From page 21 responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. DAS-J stated that they had not had an opportunity to update the policy to make it site specific and currently combined the plan to include the whole campus which consisted of the hospital and long-term care facility. Record review of the fire safety evacuation drills for employees were being done quarterly and not twice per year per shift with at least one evacuation drill every other month. DAS-J stated that these drills were being done by employees quarterly and the record log indicated that they were done in March 2024 and June 2024. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01290 SS=E	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction	01290		

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01290	Continued From page 22 does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was affiliated with the assisted living license for two of three employees (registered nurse (RN)-F, RN-H). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: RN-F was hired January 27, 2022, at the hospital campus. RN-F's license was issued June 29, 2016, with renewal date of July 31, 2026. The licensee's Net Study 2.0 report from the hospital campus indicated RN-F's background study was cleared April 20, 2022. RN-H was hired June 29, 2017, at the hospital campus. RN-H's license was issues June 27, 2012, with renewal date of April 30, 2026. The licensee's Net Study 2.0 report from the hospital campus indicated RN-H's background study was cleared December 15, 2022. On July 8, 2024, at 10:50 a.m., during the entrance conference licensed assisted living	01290		

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01290	Continued From page 23 director (LALD)-A and clinical nurse supervisor (CNS)-B stated the director of nursing at the hospital is the backup nurse for the CNS, and other hospital nurses will come to the assisted living nights, evenings and weekends to assess after a fall or other concerns as needed. On July 9, 2024, at 2:52 p.m., LALD-A stated RN-F and RN-H and other hospital nurses that come over to the assisted living are not affiliated with the assisted living license. LALD-A stated she has had conversations with human resources and leadership about this but the affiliation has not been completed. The assisted living staffing schedule posted daily July 8, 2024, through July 10, 2024, indicated if unable to reach CNS call the hospital nurses station extension [number] and keep calling until you reach someone. Hospital RN staff is backup call 24/7 when staff nurse is not available. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe	01370		

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01370	Continued From page 24 environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations included all the required training for one of two unlicensed personnel (ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01370		

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01370	Continued From page 25 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-D had a hire date of April 21, 2023, to provide direct care services. On July 8, 2024, at 2:42 p.m., the surveyor observed ULP-D administering R5's scheduled afternoon medications. ULP-D's employee record lacked evidence ULP-D received the following required training and/or competencies: -basic infection control, including blood-borne pathogens; -maintenance of a clean and safe environment; -appropriate and safe techniques in personal hygiene and grooming, including care of teeth, gums an oral prosthetic device, use of hearing aids, dressing and assisting with toileting; -awareness of confidentiality and privacy; and -understanding appropriate boundaries between staff and residents and the resident's family. On July 8, 2024, at 2:48 p.m., ULP-D stated she had to do classes on the computer, met with a nurse and worked on skills, then shadowed a day, then went on her own to provide services. On July 10, 2024, at 11:42 a.m., licensed assisted living director (LALD)-A stated she looked at ULP-D's computer training and her training was not completed. Clinical nurse supervisor (CNS)-B	01370		

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	23626	A. BUILDING: _____ B. WING _____	07/10/2024

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01370	Continued From page 26 stated since taking the CNS position she started auditing training records and has found some training missing. CNS-B stated training consists of computer classes, trains with the nurse for competencies, ULP shadows another ULP, and then performs the tasks with another ULP. The licensee's Assisted Living Orientation-ULP Staff dated June 20, 2024, indicated newly hired unlicensed personnel will receive orientation and training on topics required by Minnesota statutes. The policy indicated ULPs will receive training on the following topics with a written or oral competency test: -basic infection control, including blood-borne pathogens; -maintenance of a clean and safe environment; -appropriate and safe techniques in personal hygiene and grooming, including care of teeth, gums an oral prosthetic device, use of hearing aids, dressing and assisting with toileting; -awareness of confidentiality and privacy; and -understanding appropriate boundaries between staff and residents and the resident's family. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
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	01460		

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01460	Continued From page 27 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 licensee failed to ensure staff providing and supervising direct care services completed an orientation to assisted living facility licensing requirements and regulations before providing services for three of three employees (registered nurse (RN)-E, RN-F, RN-G). This had the potential to affect all 25 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 the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 8, 2024, at 10:50 a.m., the clinical nurse supervisor (CNS)-B stated RN-E from the campus hospital covers the CNS when she is absent in the assisted living facility during the day, and other hospital RN's cover evenings, nights and weekends, however, she will come in as needed. Licensed assisted living director (LALD)-A stated the hospital nurses do not have orientation to assisted living training and has told leadership at the hospital, but the training has not been completed yet.	01460		

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01460	Continued From page 28 RN-E was hired June 29, 2017, at the campus hospital. RN-F was hired January 27, 2022, at the campus hospital. RN-G was hired September 18, 2023, at the campus hospital. RN-E, RN-F, and RN-G's employee records lacked evidence of completing orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The assisted living staffing schedule posted daily July 8, 2024, through July 10, 2024, indicated if unable to reach the CNS call the hospital nurses station extension [number] and keep calling until you reach someone. Hospital RN staff is backup call 24/7 when staff nurse is not available. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460		
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;	01650		

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01650	Continued From page 29 (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan was updated for one of two residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4 was admitted on July 1, 2014, and started to receive services under the assisted living license	01650		

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01650	Continued From page 30 on August 1, 2021. R4's diagnoses included chronic kidney disease, heart failure, and hypertension (high blood pressure). R4's service plan dated April 1, 2019, indicated R4 was independent with medication management, and received assistance with housekeeping and laundry. R4's medication management plan dated April 1, 2019, indicated R4 was independent with medications management. R4's care plan revised on May 28, 2024, indicated resident is independent with self-administration of medications. R4's progress note dated June 7, 2024, by clinical nurse supervisor (CNS)-B indicated "Staff are now going to be doing his medications. Occupational therapy (OT) did a cognition test and recommended that he have help with his medications. He has a lidocaine gel and cream that he will continue to administer himself at this time. He is in agreement that he may need help with his oral medications. He stated he felt he was doing ok with them but if others feel he needs help, then that is what he will do." R4's assisted living tenant evaluation dated June 10, 2024, indicated medications must be administered by staff. R4's electronic medication administration record (EMAR) indicated staff administered oral medication from June 7, 2024, through July 9, 2024.	01650		

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01650	Continued From page 31 On July 10, 2024, at 11:50 a.m., CNS-B stated R4's service plan was not updated to reflect he was no longer capable to self administer his medications. CNS-B stated she was not aware of the service plan form, and it was not completed. CNS-B stated she verbally talked to him and his daughter about the increase in cost. The licensee's Service/Care Plan policy dated January 5, 2024, indicated service/care plans and any revisions or updated will be entered into the residents record, including notice of change of fees when applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to renew prescriptions at least every 12 months 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, but was not likely to cause serious injury, impairment, or death) and	01830		

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01830	Continued From page 32 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: During the entrance conference on July 8, 2024, at 10:50 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to the residents at the facility. R1's diagnoses included diabetes, arthritis, and hypertension (high blood pressure). R1's service plan dated November 30, 2021, indicated R1 received services which included medication management and administration. R1's provider orders dated January 18, 2023, included the following medications: - A & D ointment (skin condition) two times a day. - amlodipine 10 milligram (mg) (for high blood pressure) daily. - antacid suspension 200-200-20 mg/5 milliliter (ml) (for indigestion) twice daily as needed. - artificial tears solution 0.4% (dry eyes) four times a day as needed. - aspirin 81 mg (high blood pressure) daily. - Basaglar Kwikpen insulin 100 units/ml (diabetes), inject 10 units at bedtime. - losartan potassium HCTZ 50-12.5 mg (high blood pressure) daily. - milk of magnesia 400 mg/5 ml (constipation) daily as needed. - multivitamin (supplement) daily. - Novolog Flexpen insulin 100 units/ml (diabetes), inject 4 units before meals. - Nystatin ointment 100000 unit/gram (gm)	01830		

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01830	Continued From page 33 (redness), two times daily as needed. - Robitussin chest congestion syrup 100 mg /5 ml (cough) every four hours as needed. - rosuvastatin calcium 20 mg (high cholesterol) daily. - Rybelsus tablet 14 mg (diabetes) daily. - Tylenol 325 mg (pain/temperature) two tablets every 4 hours as needed. - vitamin B complex (supplement) daily. - vitamin C 250 mg (supplement) daily. - vitamin D3 50 micrograms (mcg) (supplement) daily. - zinc acetate 50 mg (supplement) daily. R1's provider order dated June 16, 2023, included the Free Style Libre 3, but did not include frequency of blood glucose (blood sugar) checks. R1's July 2024 electronic medication administration record (EMAR) listed medications as prescribed above, times to administer, and staff initials to indicate the medications had been given. Also included on the EMAR was documentation of blood glucose results before meals and at bedtime and as needed. On July 9, 2024, at 11:34 a.m., the surveyor observed unlicensed personnel (ULP)-D administer R1's afternoon medications. On July 10, 2024, at 12:11 p.m., clinical nurse supervisor CNS-B stated an updated medication list should have been added in R1's medical record. CNS-B stated the licensee also has access to the clinic records, so will ensure to get a copy of provider orders in her medical record. The licensee's Documentation of Medication, Treatment and Therapy Management Service	01830		

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01830	Continued From page 34 dated June 20, 2024, indicated for receiving and requesting prescription and refills the nurse will document actions to implement a new prescription when it is received, and actions to request and obtain needed refills for clients, including communication the prescriber, pharmacy, client and/or clients representative or family. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01830		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to date time-sensitive medications with opened or expiration dates for one of one resident (R6). 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	01890		

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01890	Continued From page 35 situation has occurred only occasionally). The findings include: On July 8, 2024, at 12:42 p.m., the surveyor observed medication cart with clinical nurse supervisor (CNS)-B. CNS-B stated staff are trained to label time sensitive medications and confirmed the following: -R6's latanoprost 0.00005% eye drop (treats glaucoma), lacked an open and expiration date. Date written on sticker was June 20, 2024, sticker did not indicate if the date was open or expiration date. The manufacturer's instructions for latanoprost eyedrops dated March 2022, indicated to use within four weeks of opening A medication storage policy was requested during survey, but no policy was received. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed	01950		

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01950	Continued From page 36 personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse documented resident-specific instructions for a treatment for one of one resident (R1) whose blood glucose (blood sugar) monitoring was delegated to unlicensed personnel (ULP). 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: On July 9, 2024, at 11:34 a.m., the surveyor observed ULP-D prepare R1's Novolog Flexpen insulin and observed R1 use her phone to obtain blood glucose reading from Freestyle Libre 2 device on right arm. ULP-D stated there are no specific instructions on the electronic medication administration record (EMAR) but we are "taught	01950		

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01950	Continued From page 37 to call a nurse if it was below 70 or above 300 I think." R1's, EMAR dated July 1, 2024, through July 9, 2024, included the following: - blood glucose from Free Style Libre 3 was documented with insulin injection before meals and at bedtime and as needed (PRN). The licensee failed to provide resident-specific instructions pertaining to blood glucose results (blood glucose parameters and when to notify a registered nurse (RN). On July 10, 2024, at 12:12 p.m., clinical nurse supervisor (CNS-B) stated the staff are trained when to call the nurse about blood glucose. CNS-B stated the EMAR was lacking specific instructions in regards to blood glucose parameters and when to notify a nurse. The licensee's Documentation of Medication, Treatment and Therapy Management Services dated June 20, 2024, indicated the RN will document the services the client will receive on the clients individualized medication plan and individualized treatment and therapy plan and client's medication/treatment record. The RN will provide specific instructions for administering PRN medications, treatments and therapy consistent with the prescriber's prescription for the reason/circumstances under which the PRN's may be administered. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		

MN Department of Health
Food, Pools, and Lodging Services
PO Box 64975
St. Paul, MN 55164-0975
218-332-5150

Type: Full
Date: *07/09/24*
Time: 12:19:21
Report: 7935241026

Food and Beverage Establishment Inspection Report

Location:
Apple Ridge Estates
100 South Barduson Street
Appleton, MN56208
Swift County, 76

Establishment Info:
ID #: 0038299
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3202891580
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.

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

DOMESTIC CABINETRY IS WEARING OUT.

Comply By: 12/31/24

6-100 Physical Facility Construction Materials

6-101.11A1

MN Rule 4626.1325A1 Provide smooth, durable, and easily cleanable floor, wall and ceiling surfaces.

WALL SURFACES BEHIND SINKS AND DISH MACHINE ARE DAMAGED. PROVIDE APPROVED DURABLE WALL COVERINGS.

Comply By: 01/31/25

6-200 Physical Facility Design and Construction

6-202.11A

MN Rule 4626.1375A Provide effective shielding, coated or shatter-resistant light bulbs for all light fixtures where there is exposed food, clean equipment, utensils and linens, or unwrapped single-service or single-use articles.

DRY STAGE ROOM.

Comply By: 07/09/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.114AB

MN Rule 4626.1580AB Remove all items unnecessary to the operation or maintenance of the establishment and litter from the premises.

REMOVE UNNECESSARY ITEMS FROM DRY STORAGE ROOM.

Comply By: 07/09/24

Surface and Equipment Sanitizers

Quaternary Ammonia: = at 165 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Hot Water: = 200 ppm at Degrees Fahrenheit
Location: Spray Bottle
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 193 Degrees Fahrenheit - Location: Omlette
Violation Issued: No

Process/Item: Hot Holding
Temperature: 153 Degrees Fahrenheit - Location: Oatmeal
Violation Issued: No

Process/Item: Hot Holding
Temperature: 164 Degrees Fahrenheit - Location: Sausages
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: Kelvinator
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	4

Type: Full
Date: *07/09/24*
Time: 12:19:21
Report: 7935241026
Apple Ridge Estates

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 MN Department of Health inspection report number 7935241026 of 07/09/24.

Certified Food Protection Manager: Lynell Dwyer

Certification Number: 58782 Expires: 08/04/26

Signed:_____
Establishment Representative

Signed: Rebecca Tonneson
Rebecca Tonneson
Public Health San Supervisor
Fergus Falls District Office
218-332-5142
rebecca.tonneson@state.mn.us