Electronically Delivered

February 24, 2022

Administrator
Apple Valley Village Assisted
14610 Garrett Avenue
Apple Valley, MN 55124

RE: Project Number(s) SL30611015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on February 3, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

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

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

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

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

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The licensee is not required to submit a plan of correction 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 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 the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place

St. Paul, MN 55164-0970 St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30611	A. BUILDING: _____ B. WING _____	02/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE ASSISTED	14610 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 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: SL30611015 On February 1, 2022, through February 3, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 215 residents; 75 residents were receiving services under the provider's Assisted Living Facility with Dementia Care license. The provider is in substantial compliance, no further actions are required.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living with Dementia Care licensed providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	0 780		

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0 780	Continued From page 1 (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 provide the required smoke alarms and interconnection of smoke alarms as required by Minnesota Statutes, 144G.45, Subd. 2. This has 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	0 780		

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0 780	Continued From page 2 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 February 2, 2022, survey staff toured the facility with the house manager(HM)-B and the the director of maintenance (DM)-H. The DM-H joined the tour at approximately 10:00 a.m. MISSING SMOKE ALARMS On February 2, 2022, between the hours of 9:15 a.m. to 11:50 a.m. and again between the hours of 1:00 p.m. to 2:40 p.m., survey staff observed missing smoke alarms at the following locations: -Outside in the immediate vicinity of sleeping rooms inside suite #502 (higher level care). -Outside in the immediate vicinity of sleeping rooms inside resident room #135 and related stacks of four resident rooms. -Outside in the immediate vicinity of sleeping rooms inside resident room #254 and related stacks of four resident rooms. -Outside in the immediate vicinity of sleeping rooms inside resident room #218 and related stacks of four resident rooms. -Outside in the immediate vicinity of sleeping rooms inside resident room #434 and related stacks of four resident rooms. -Outside in the immediate vicinity of sleeping rooms inside resident room #440 and related stacks of four resident rooms. -Outside in the immediate vicinity of sleeping rooms inside resident room #301 and related stacks of four resident rooms. -Outside in the immediate vicinity of sleeping rooms inside resident room #337 and related stacks of four resident rooms.	0 780		

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0 780	Continued From page 3 On February 2, 2022, between the hours of 10:00 a.m. to 11:50 a.m. and again between the hours of 1:00 p.m. to 2:40 p.m., the findings above were verified by the HM-B and the DM-H during the tour as they explained each room consisted of four resident rooms with same design with four rooms to a stack. INTERCONNECTION OF SMOKE ALARMS On February 2, 2022, at approximately 10:00 a.m., survey staff observed smoke alarms in sleeping rooms inside suite #501 (memory care) and suite #502 (higher level care) were battery operated and were not interconnected as required with the smoke alarms outside the hallway in the immediate vicinity of sleeping rooms. This was verified by the housing manager-B and the DM-H during the tour as the DM-H tested the smoke alarms in the sleeping rooms and the smoke detector outside in the vicinity of the sleeping rooms inside suite 502 did not sound. On February 2, 2002, between the hours of 10:40 a.m. and 11:30 a.m., survey staff observed battery smoke alarms inside resident sleeping rooms of rooms 337, 407, 438, 443, and 448, only sounded local, and not interconnected with the smoke detectors (hardwired to the building alarm system) installed outside within the vicinity of the sleeping rooms to sound throughout the resident room. The findings were evident when smoke alarms inside the listed sleeping rooms were tested by the DM-H, and the alarms outside the hallway in the immediate vicinity of each of the listed sleeping rooms did not alarm. This was verified by the housing manager-B and the DM-H during the tour as they explained the rooms were part of a stack of four with similar design. DM-H explained that the facility may considered	0 780		

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0 780	Continued From page 4 purchasing battery smoke alarms similar to the existing battery operated alarms inside sleeping rooms and interconnect using wireless technology since the existing alarms are hardwired and connected to the building alarm system. On February 2, 2002, at approximately 11:30 a.m. and again at 2:30 p.m., survey staff explained to the HM-B and the DM-H that the missing smoke alarms outside the hallway in the vicinity of sleeping rooms must be interconnected with the sleeping room smoke alarms for each room and this applied throughout the building. On February 2, 2022, at approximately 4:35 p.m., the HM-B, the licensed assisted living director (LALD)-G and the administrator (ADM)-I acknowledged the above findings at the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire	0 790		

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0 790	Continued From page 5 Code; and This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to maintain portable fire extinguishers in accordance with the State Fire Code as required by MN Statute 144G.45 Subd(a)(2). This had the potential to directly affect all residents and 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) 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 February 2, 2022, between the hours of 9:15 a.m. to 11:50 a.m. and again between the hours of 1:00 p.m. to 2:40 p.m., survey staff toured the facility with the HM-B and the the director of maintenance (DM)-H. The DM-H joined the tour at approximately 10:00 a.m. During the tour, survey staff observed portable fire extinguishers located throughout the facility, including the kitchen, lower level, 1st, 2nd, 3rd, 4th, and 5th floors, were consistently tagged showing the required annual service date of October 2021, but all lacked the records to show the required monthly visual inspections to date. The the last monthly visual inspected on the tags of the extinguishers were all observed with the date of October 5, 2021.	0 790		

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0 790	Continued From page 6 On February 2, 2022, at approximately 10:50 a.m., DM-H confirmed the findings during the tour as he stated he will check with maintenance for records of the visual monthly inspections on portable fire extinguishers. Survey staff explained that the monthly visual inspection of each extinguisher was necessary to ensure all portable extinguishers are readily available, fully charged, and operable at their designated location, and no obvious physical damage or condition to the extinguisher to prevent their operation when needed. If extinguishers were comprised or questionable, the licensee will need to get them to a vendor for servicing such as recharging or maintenance. On February 2, 2022, at approximately 1:00 p.m., the DM-H clarified there were no other records available for the portable fire extinguishers. The DM-H and the HM-B confirmed the findings throughout the facility while on tour. On February 2, 2022, at approximately 4:35 p.m., the HM-B, the licensed assisted living director (LALD)-G and the administrator (ADM)-I acknowledged the above findings at the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=E	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	0 800		

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0 800	Continued From page 7 good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents, visitors, and 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On February 2, 2022, between the hours of 9:15 a.m. to 11:50 a.m. and again between the hours of 1:00 p.m. to 2:40 p.m., survey staff toured the facliity with the HM-B and the the director of maintenance (DM)-H. The DM-H joined the tour at approximately 10:00 a.m. During the tour, survey staff observed the following: -The exterior walkway serving the marked exit door (near Room 135) was covered with snow and not maintained for safe means of egress to the roadway. -The mop sink faucet with integral backflow in boiler room 028 was altered by adding an unapproved "Y" fitting connection on the faucet. This installation has the potential to create cross	0 800		

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0 800	Continued From page 8 connection between the chemical and the water supply piping. The faucet must have pressure bleeding device installation for to an ASSE 1055 chemical soap dispenser. A "Y" connection does not allow for the required pressure bleeding device installation. Consult with your local licensed plumbing contractor or your authorized chemical soap dispenser company. On February 2, 2022, at approximately 4:35 p.m., the HM-B, the licensed assisted living director (LALD)-G and the administrator (ADM)-I acknowledged the above findings at the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation	0 810		

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0 810	Continued From page 9 plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the licensee failed to have the floor plan of the lower level readily available as part of the fire safety and evacuation plan, records of required training of staff and residents on their fire safety and evacuation plan, and a minimum number of evacuation drills performed. This has the potential to directly affect the safety of visitors, staff, and all residents receiving assisted living care. 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:	0 810		

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0 810	Continued From page 10 On February 2, 2022, at approximately 2:45 p.m., survey staff reviewed the facility's fire safety and evacuation plan documentation, training policies and procedures, and related records. FIRE SAFETY AND EVACUATION PLAN: The floor plan for the lower level was not readily available within the facility or in the fire safety and evacuation plan. While on tour at approximately 2:00 p.m. in the lower level, the director of maintenance (DM)-H verified this finding as he attempted to locate the lower level floor plan, but was not successful. This finding was also evident when staff reviewed the fire safety and evacuation plan, the building's lower floor plan did not match up with the existing layout as the plan showed a swimming pool that did not exist. Discrepancies also existed between the posted floor plans near elevator lobbies for the other floors compared to the floor layout plans in the binder. The licensee is required to develop and maintain accurate fire safety and emergency evacuation plan and readily available TRAINING The facility's fire plan policy revised and dated, July 1, 2021, showed the incorrect frequency of employee training on fire safety and evacuation of new employee orientation and annually. The minimum required training is upon hire and twice a year. There was no policy document provided to show training of residents that can self assist in their evacuation during on the proper actions to be taken in the event of a fire including movement, evacuation, or relocation. The policy must address residents on all floors receiving care as well as any applicable residents with dementia care and higher level care on the fifth floor as determined by their plan to be capable of	0 810		

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0 810	Continued From page 11 self-assist. FIRE DRILLS AND EVACUATION The facility's policy revised and dated July 1, 2021, showed complying minimum numbers of required evacuation drills that must be performed by employees twice per year per shift, with at least one evacuation drill every other month for Minnesota locations. However, record review showed insufficient evacuation drills performed to date by employees. Documented records received via email from the licensee dated February 4, 2022, at 1:29 p.m., showed the last fire drills were performed on August 9, 2021 at 6:15 a.m. and January 7, 2022, at 2:05 p.m., and no noted evacuation details in the fire drill records. On February 2, 2022, at approximately 4:35 p.m., the housing manager (HM)-B, the licensed assisted living director (LALD)-G and the administrator (ADM)-I acknowledged the above findings at the exit interview. On February 2, 2022, at approximately 4:35 p.m., the HM-B and ADM-I explained that the wrong floor plans were in the binder and that they will email the lower level floor plan to survey staff. Additional information was received by the licensee via email on February 4, 2022, between 1:29 p.m. to 1:32 p.m., for the 1) August 2021 fire drill record, sign-in sheet and resident education from the October 2021 drill, and copies of the January 2022 drill along with resident education, 2) Fire Plan revised and dated July 1, 2021, and 3) a copy of our lower-level emergency exit sign. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30611	A. BUILDING: _____ B. WING _____	02/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE ASSISTED	14610 GARRETT AVENUE APPLE VALLEY, MN 55124

(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
02040	Continued From page 12	02040		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide a complete facility hazard vulnerability or safety risk assessment (HVA) plan to identify both hazards and mitigations on and around the property. The hazards indicated on the HVA plan must be assessed and mitigated to protect the residents from harm. This has the potential to directly affect all dementia care residents receiving assisted living 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) 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:	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30611	A. BUILDING: _____ B. WING _____	02/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE ASSISTED	14610 GARRETT AVENUE APPLE VALLEY, MN 55124

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02040	Continued From page 13 On February 2, 2022, survey staff toured the facliity with the house manager (HM)-B and the the director of maintenance (DM)-H between the hours of 9:15 a.m. to 11:50 a.m. and again between the hours of 1:00 p.m. to 2:40 p.m. The DM-H joined the tour at approximately 10:00 a.m. On February 2, 2022, at approximately 2:45 p.m., survey staff received the HVA documentation for review: -The HVA plan documentation lacked all the contents of the hazard vulnerability assessment to specifically include a comprehensive hazard assessment on and around the property of the facility to protect the memory care residents from harm. The hazard assessments on the HVA plan need to be expanded further in scope to include specific safety risks or potential hazard vulnerabilities such as resident elopement throughout and around the memory care suite including deactivation of power doors due to loss of power or fire alarm activation, the risks of resident harm from windows being comprised such as a window in bedroom #1 in memory care suite 501 adjacent to the 5th-floor balcony, resident risks of harm from stovetop, toaster, and small knives in drawers accessible to the residents in the kitchenette in memory care suite 501, potential harm to residents from accessing the electrical panel in the hallway of the suite, and the potential risks of the misuse of architectural accessories in the suite. - The HVA plan lacked mitigations to the hazard identified in the plan. All hazards assessed on the plan and additional hazards identified on and around the property to protect all memory care residents from harm must be provided with	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30611	A. BUILDING: _____ B. WING _____	02/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE ASSISTED	14610 GARRETT AVENUE APPLE VALLEY, MN 55124

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02040	Continued From page 14 mitigations and/or safety measures to minimize harm. On February 2, 2022, at approximately 4:35 p.m., the HM-B, the DM-H, the licensed assisted living director (LALD)-G and the administrator (ADM)-I acknowledged the above findings at the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02040		

Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
Saint Paul
651-201-4500

Type: Full
Date: *02/02/22*
Time: 10:03:32
Report: 1018221019

Food and Beverage Establishment Inspection Report

Location:
Apple Valley Village Assisted
14610 Garrett Avenue
Apple Valley, MN55124
Dakota County, 19

Establishment Info:
ID #: 0038352
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9522362600
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.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

RAW BEEF OBSERVED TO BE STORED OVER READY TO EAT FOODS IN THE DELI KITCHEN COOLER. DISCUSSED WITH STAFF TO MOVE THE BEEF TO THE BOTTOM SHELF.

Comply By: 02/02/22

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: 3 COMPARTMENT SINK
Violation Issued: No

Hot Water: = at 171 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: 3 COMPARTMENT SINK
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding/ CHEESE
Temperature: 39 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Food and Beverage Establishment Inspection Report

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

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

Process/Item: Cold Holding/ LETTUCE
Temperature: 39 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: Cold Holding/ HAM
Temperature: 38 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: Cold Holding/ TOMATO
Temperature: 36 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: Cold Holding/ HAM
Temperature: 38 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

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

Process/Item: Cold Holding/ CHEESE
Temperature: 37 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

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

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

VIEWED COOKING LOGS, THERMOMETER CALIBRATION LOGS AND DISHWASHER TEMPERATURE LOGS.

DISCUSSED ILLNESS POLICY WITH MANAGER.

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1018221019 of 02/02/22.

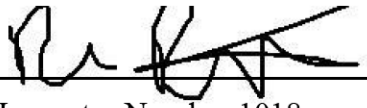
Certified Food Protection Manager: MARK T TESMER

Certification Number: FM92097 Expires: 12/29/22

Inspection report reviewed with person in charge and emailed.

Signed: _____

MARK TESMER
KITCHEN MANAGER

Signed: 

Inspector Number 1018

6512014500

Report #: 1018221019

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
Saint Paul

No. of RF/PHI Categories Out	1	Date	02/02/22
No. of Repeat RF/PHI Categories Out	0	Time In	10:03:32
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Apple Valley Village Assisted	14610 Garrett Avenue	Apple Valley, MN	55124	9522362600

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0038352		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status		COS	R
Supervision			
1 IN OUT	PIC knowledgeable; duties & oversight		
2 IN OUT N/A	Certified food protection manager, duties		
Employee Health			
3 IN OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4 IN OUT	Proper use of reporting, restriction & exclusion		
5 IN OUT	Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices			
6 IN OUT N/O	Proper eating, tasting, drinking, or tobacco use		
7 IN OUT N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands			
8 IN OUT N/O	Hands clean & properly washed		
9 IN OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10 IN OUT	Adequate handwashing sinks supplied/accessible		
Approved Source			
11 IN OUT	Food obtained from approved source		
12 IN OUT N/A N/O	Food received at proper temperature		
13 IN OUT	Food in good condition, safe, & unadulterated		
14 IN OUT N/A N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination			
15 IN OUT N/A N/O	Food separated and protected		
16 IN OUT N/A	Food contact surfaces: cleaned & sanitized		
17 IN OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status		COS	R
Time/Temperature Control for Safety			
18 IN OUT N/A N/O	Proper cooking time & temperature		
19 IN OUT N/A N/O	Proper reheating procedures for hot holding		
20 IN OUT N/A N/O	Proper cooling time & temperature		
21 IN OUT N/A N/O	Proper hot holding temperatures		
22 IN OUT N/A	Proper cold holding temperatures		
23 IN OUT N/A N/O	Proper date marking & disposition		
24 IN OUT N/A N/O	Time as a public health control: procedures & records		
Consumer Advisory			
25 IN OUT N/A	Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations			
26 IN OUT N/A	Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances			
27 IN OUT N/A	Food additives: approved & properly used		
28 IN OUT	Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures			
29 IN OUT N/A	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30	IN OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT N/A	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 02/04/22

Inspector (Signature)