Electronically Delivered

July 28, 2023

Licensee
Orchards Of Minnetonka
10955 Wayzata Boulevard
Minnetonka, MN 55305

RE: Project Number(s) SL34716015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 19, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The 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 and enforcement actions 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 the MDH within 15 calendar days of the correction order receipt date.

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

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
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 the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 651-281-9796

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34716	A. BUILDING: _____ B. WING _____	07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARDS OF MINNETONKA	10955 WAYZATA BOULEVARD MINNETONKA, MN 55305

(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: SL34716015-0 On July 17, 2023, through July 19, 2023, 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 143 active residents; 66 of whom were receiving services under the Assisted Living with Dementia Care 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 License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports, dated July 17, 2023. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the	0 510		

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0 510	Continued From page 2 national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control. The deficient practice had the potential to affect residents, employees, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: Unlicensed personnel (ULP)-E was hired on November 25, 2019. ULP-E's Educare (online training platform) transcript indicated completion of infection control training on February 8, 2023. ULP-G was hired on September 19, 2022. ULP-G's Educare transcript indicated completion of infection control training on January 5, 2023.	0 510		

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0 510	Continued From page 3 On July 19, 2023, at 8:56 a.m., observed ULP-E and ULP-G providing cares for R6 which included a soiled brief (adult incontinence product) change, disposable chux pad (absorbent pad) change, and transfer sheet change. ULP-E and ULP-G completed R6's brief change and doffed (removed) their gloves. ULP-E and ULP-G then left R6's room and apartment without performing hand hygiene carrying a garbage bag. ULP-E stated to ULP-G to make sure they washed their hands on their way out of the room. ULP-E and ULP-G touched the door handle on the way out of the room with soiled hands. ULP-E and ULP-G touched door handles in the hallway to access the bathroom and garbage room with soiled hands. ULP-G stated the licensee did not want them to wash their hands in a resident's apartment and should instead use the bathrooms outside of the apartments in the hallways. ULP-G stated they had not used any hand sanitizer after doffing their gloves and before exiting the apartment as they didn't have any with them. On July 19, 2023, at 9:54 a.m., registered nurse (RN)-H stated staff were instructed not to use residents' personal soap but still needed to at least use hand sanitizer after doffing gloves until they were able to wash their hands with soap and water. The licensee's Gloves - Procedure For Using policy dated August 1, 2021, indicated: "1. Wash Hands 2. Apply gloves to both hands 3. Remove contaminated materials 4. Place materials in proper receptacle - such as biohazardous waste for wound care dressings with dripable or squishable blood/fluids. 5. Remove gloves by:	0 510		

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0 510	Continued From page 4 Grasping cuff of one glove and pulling it off, turning it inside out With ungloved hand tuck finger inside cuff of remaining glove and pull off, turning inside out 6. Dispose of in proper receptacle 7. Rewash hands 8. Do not re-use disposable gloves" No further information provided. TIME PERIOD FOR CORRECTION: Two (2) Days	0 510		
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	0 810		

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0 810	Continued From page 5 include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a maintained fire safety and evacuation plan that showed the location and number of resident rooms. 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: An interview and record review were conducted on July 18, 2023, at approximately 9:00 a.m. with the Licensed Assisted Living Director (LALD)-C and the Environmental Services Director (ESD)-F on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility.	0 810		

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0 810	Continued From page 6 On the facility tour with the LALD-C and ESD-F on April 10, 2023, at approximately 9:00 a.m., it was observed that the posted fire safety and evacuation plans plan did not show the location and number of resident rooms throughout the facility. This deficient condition was visually verified by LALD-C and ESD-F accompanying the tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescription medications were securely locked in a substantially constructed compartment and permitted only authorized personnel to have access. This had the potential to affect all the residents in the facility that lived in the secured memory care unit. 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).	01880		

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01880	Continued From page 7 The findings include: On July 18, 2023, at 6:30 a.m., surveyor observed unlicensed personnel (ULP)-B bring creams and ointments for two residents that included Baza moisturizing barrier cream and Remedy barrier cream into residents' rooms and leave unattended. On July 18, 2023, at 7:32 a.m., unlicensed personnel (ULP)-B stated, "I put all the creams in each of the [resident] rooms first thing each day and then when the resident is ready to get up or be toileted then I can go back in at that time and apply the cream." Surveyor asked how they ensure the medications are secured when left in room or when the cart is left unlocked. ULP-B stated, "I can't guarantee nobody will get into them, should I go grab them and lock the creams in my cart?" On July 18, 2023, at 10:12 a.m., registered nurse (RN)-A stated, "All medications in memory care [secured unit] need to be administered by the staff. Medications should be in kept in the med cart and cart should be locked. Creams should be kept in the bottom drawer because that is considered a medication so those can't be kept in the residents' room." The licensee's Storage of Medication and Key Security policy dated April 19, 2023, indicated when secured storage of the medications is necessary, the nurse will identify where the medications will be stored, how they will be secured or locked under proper temperature controls and who has access to the medications. No further information was provided.	01880		

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01880	Continued From page 8 TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
02410 SS=F	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure privacy was maintained for one of one resident (R3) observed during medication and treatment administration.	02410		

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02410	Continued From page 9 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 18, 2023, at 7:58 a.m., R3 was seated in the common area by the dining room with other residents. Unlicensed personnel (ULP)-B approached R3 carrying supplies to complete a blood glucose monitoring check. ULP-B advised R3 they be administering a blood glucose check. ULP-B then pushed R3 in a wheelchair a few feet back from the closest resident and ULP-B stated she was going to administer the insulin into R3's stomach and lifted R3's shirt up to expose the area. ULP-B then cleansed R3's stomach area and administered R3's insulin. On July 19, 2023, at 7:52 a.m., R3 was seated in the common area by the dining room with other residents. ULP-B announced to R3 and another ULP that they needed to keep R3 in the common area so they could administer insulin. ULP-B approached R3 and had R3 lift their shirt to expose the area. ULP-B then cleansed the stomach area and administered R3's insulin. On July 18, 2023, at 10:15 a.m., registered nurse (RN)-A stated, "insulin should be done in a private area, and I have caught the aides giving insulins in public areas before and I always re-educate. We try to keep the med cart down on the one end of the unit away from the dining room because	02410		

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02410	Continued From page 10 there is a private alcove over there for eye drops, creams, or insulins to give the residents privacy. But some of the aides keep moving the cart and then giving insulins by wherever they park the cart, and we keep telling them they can't be doing that." On July 19, 2023, at 7:58 a.m., ULP-B stated, "If they [resident] are in their room we will administer [insulin] in the room. If they are out of their room, we do it [administer insulin] out here, but not in the dining room." The licensee's Medication and Treatment Implementation policy dated August 1, 2021, lacked instructions for providing privacy during medication or treatment administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		

DEPARTMENT OF HEALTH

Type: Full
Date: *07/17/23*
Time: 10:02:14
Report: 1036231179

Food and Beverage Establishment Inspection Report

Location:

Orchards Of Minnetonka
10955 Wayzata Boulevard
Minnetonka, MN55305
Hennepin County, 27

Establishment Info:

ID #: 0038989
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 7634171077
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.

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.14A

MN Rule 4626.1530A Maintain clean all intake and exhaust air ducts and change filters so they are not a source of contamination.

OBSERVED SOME DUST ACCUMULATION ON THE FILTERS IN THE HOOD ABOVE THE STOVE AND THE INTAKE AIR DUCTS ABOVE THE PREP TABLES. CLEAN AT A GREATER FREQUENCY TO PREVENT SUCH ACCUMULATION.

Comply By: 07/31/23

Surface and Equipment Sanitizers

UTENSIL SURFACE TEMP: = at 163.2 Degrees Fahrenheit
Location: HOT WATER DISH MACHINE
Violation Issued: No

QUATERNARY AMMONIA: = 300 PPM at Degrees Fahrenheit
Location: 3 COMP SINK DISPENSER
Violation Issued: No

QUATERNARY AMMONIA: = 200 PPM at Degrees Fahrenheit
Location: KITCHEN SANI BUCKET
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/PEA SOUP
Temperature: 35 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Cold Hold/SLICE TOMATO
Temperature: 39 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: Cold Hold/SOUR CREAM
Temperature: 41 Degrees Fahrenheit - Location: HOSHIZAKI DOUBLE DOOR COOLER
Violation Issued: No

Process/Item: Cold Hold/MILK
Temperature: 38 Degrees Fahrenheit - Location: HOSHIZAKI SMALL COOLER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: -1 Degrees Fahrenheit - Location: WALK IN FREEZER
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR FROM HRD WAS TESA BROWN. INSPECTION CONDUCTED IN PRESENCE OF DANIEL GELTZ, THE CFPM. ALL VIOLATIONS WERE DISCUSSED WITH PERSON IN CHARGE AND HRD EVALUATOR DURING INSPECTION.

Discussed the following with CFPM:
Employee illness policy and logging requirements
Glove-use
Handwashing procedure
No bare hand contact with ready to eat food
Thermometer use/calibration
Proper food storage
Sanitizing procedures for food contact surfaces
Fully cooking food for high risk populations
Violations on this report

**IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE CUSTOMER. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

Type: Full
Date: *07/17/23*
Time: 10:02:14
Report: 1036231179
Orchards Of Minnetonka

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 inspection report number 1036231179 of 07/17/23.

Certified Food Protection Manager: DANIEL J. GELTZ

Certification Number: FM87760 Expires: 02/22/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
DANIEL GELTZ
KITCHEN MANAGER

Signed: _____
Jeff Johanson