Electronically Delivered

June 16, 2026

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

RE:  Project Number(s) SL36035016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 30, 2026, 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 . . ."

**IMPOSITION OF FINES**

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

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

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

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

**0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00**

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

**REQUESTING A HEARING**
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating

factor.

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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.

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

If you have any questions, please contact me.

Sincerely,

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

JMD

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 36035 | A. BUILDING: _____ B. WING _____ | 04/30/2026 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 0 000 | Initial Comments<br><br>*****ATTENTION*****<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS<br><br>SL36035016-0<br><br>On April 27, 2026, through April 30, 2026, 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 three (3) residents; 3 receiving services under the Assisted Living Facility license. | 0 000 | Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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. | |
| 0 470 SS=F | 144G.41 Subdivision 1 Minimum requirements<br><br>(11) develop and implement a staffing plan for | 0 470 | | |

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| 0 470 | Continued From page 1<br><br>determining its staffing level that:<br>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;<br>(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<br>(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;<br>(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:<br>(i) awake;<br>(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;<br>(iii) capable of communicating with residents;<br>(iv) capable of providing or summoning the appropriate assistance; and<br>(v) capable of following directions;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to post a daily staff schedule in a central location. This had the potential to affect all residents and visitors.<br><br>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 | 0 470 | | |

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| 0 470 | Continued From page 2<br><br>is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On April 27, 2026, at 10:14 a.m., the surveyor observed the schedule posted in the common area lacked dates and included names of employees that were not listed on the employee roster.<br><br>On April 27, 2026, at 10:43 a.m., owner/unlicensed personnel (O/ULP)-A stated the posted schedule was old and would be replaced with an updated weekly schedule.<br><br>On April 28, 2026, at 2:44 p.m., the surveyor observed that the weekly schedule had not been changed. Assistant/unlicensed personnel (A/ULP)-B stated that two of the employees on the currently posted schedule no longer worked for the licensee and they would post an updated schedule.<br><br>The licensee's Staffing policy dated March 11, 2024, indicated a daily staffing schedule would be prepared by the clinical nurse supervisor and would be posted at the beginning of each shift in a central location.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 470 | | |
| 0 480 SS=F | 144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services | 0 480 | | |

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| 0 480 | Continued From page 3<br><br>(a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.<br>(b) For an assisted living facility with a licensed capacity of ten or fewer residents:<br>(1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation;<br>(2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570;<br>(3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage;<br>(4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink;<br>(5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, | 0 480 | | |

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| 0 480 | Continued From page 4<br><br>existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition;<br>(6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and<br>(7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 27, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. | 0 480 | | |

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| 0 480 | Continued From page 5<br><br>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. | 0 480 | | |
| 0 580 SS=F | 144G.42 Subd. 2 Quality management<br><br>The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to implement and maintain a quality management program (QMP) appropriate to the size of the licensee and relevant to the type of services provided. This had the potential to affect all current residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). | 0 580 | | |

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| 0 580 | Continued From page 6<br><br>The findings include:<br><br>On April 27, 2026, at 12:01 p.m., the surveyor requested the licensee's quality improvement plan and was provided with a white binder that contained correction orders from 2024 licensing surveys. The surveyor requested quality meeting minutes, and assistant/unlicensed personnel (A/ULP)-B stated they would provide those to the surveyor.<br><br>On April 28, 2026, at 11:15 a.m., the surveyor requested the quality management meeting minutes and was provided with the same binder that was received the day prior. No additional information had been added to the binder.<br><br>On April 28, 2026, at 12:55 p.m., A/ULP-B stated they did not have a quality management plan and had not held quality meetings. A/ULP-B denied that the licensee had implemented a quality improvement project and stated they would work with their consultant to implement a quality management program.<br><br>The licensee's Quality Improvement policy dated March 11, 2024, indicated the licensee had established a quality improvement program based on the organization's size and appropriate to the type of services provided to ensure effective, comprehensive, and appropriate plans are operational for all residents within the organization.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 580 | | |

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| 0 630 | Continued From page 7 | 0 630 | | |
| 0 630 SS=D | 144G.42 Subd. 6 (b) Compliance with requirements for reporting ma<br><br>(b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to develop an individual abuse prevention plan (IAPP) with the required content for one of three residents (R1).<br><br>This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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).<br><br>The findings include:<br><br>R1 was admitted to the licensee on October 25, 2023.<br><br>R1's signed service plan dated January 28, 2026, | 0 630 | | |

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| 0 630 | Continued From page 8<br><br>indicated R1's services included assistance with compression stockings, behavior management, blood pressure monitoring, and medication administration.<br><br>R1's IAPP completed on March 25, 2026, lacked documentation of R1's susceptibility to abuse by another individual, including other vulnerable adults.<br><br>On April 28, 2026, at 12:55 p.m., clinical nurse supervisor (CNS)-D was unavailable for an interview. Assistant/unlicensed personnel (A/ULP)-B stated they were unaware R1's IAPP was missing content and stated they would inform the nurse so that she could add the missing information.<br><br>The licensee's Vulnerable Adult policy dated March 22, 2024, indicated all of the licensee's employees would individually assess residents to determine vulnerability to abuse or neglect and develop a specific plan to minimize the risk of abuse to that resident.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 630 | | |
| 0 650 SS=F | 144G.42 Subd. 8 (a) Staff records<br><br>(a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, | 0 650 | | |

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| 0 650 | Continued From page 9<br><br>registration, or certification is required by this chapter or rules;<br>(2) records of orientation, required annual training and infection control training, and competency evaluations;<br>(3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;<br>(4) documentation of annual performance reviews that identify areas of improvement needed and training needs;<br>(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<br>(6) documentation of the background study as required under section 144.057.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure employee records included all required content for two of two employees (assistant/unlicensed personnel (A/ULP)-B, clinical nurse supervisor (CNS)-D).<br><br>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 number or all the residents).<br><br>The findings include:<br><br>A/ULP-B<br>A/ULP-B was hired on April 1, 2021, under the | 0 650 | | |

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| 0 650 | Continued From page 10<br><br>licensee's former comprehensive license and began providing assisted living services on August 1, 2021.<br><br>CNS-D<br>CNS-D was hired on March 11, 2024, and began providing assisted living services.<br><br>A/ULP-B and CNS-D's employee records lacked documentation of annual performance reviews for 2025 that identified areas of improvement and training needs.<br><br>On April 28, 2026, at 2:40 p.m., A/ULP-B stated the owner was responsible for completing the annual performance reviews and they did not know why they had not been completed.<br><br>The licensee's Personnel Records policy dated March 11, 2024, indicated performance reviews would be kept in the employee records.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 650 | | |
| 0 660 SS=F | 144G.42 Subd. 9 Tuberculosis prevention and control<br><br>(a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that | 0 660 | | |

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| | 36035 | A. BUILDING: _____ B. WING _____ | 04/30/2026 |

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

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| 0 660 | Continued From page 11<br><br>covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.<br>(b) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline TB testing for one of three employees (assisted living director in residency (ALDIR)-C).<br><br>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 number or all the residents).<br><br>The findings include:<br><br>The licensee's Facility TB Risk Assessment form was completed January 6, 2026, and identified the facility TB risk level as low.<br><br>ALDIR-C was hired on May 1, 2025, and began providing direct care services to the licensee's residents.<br><br>ALDIR-C's employee record included a TB history | 0 660 | | |

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|---|---|---|---|
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| 0 660 | Continued From page 12<br><br>and symptom screen completed on May 1, 2025, and two negative TB blood tests dated August 5, 2021, and August 4, 2022. ALDIR-C's TB blood tests were completed more than 90 days before their date of hire.<br><br>On April 28, 2026, at 12:55 p.m., assistant/unlicensed personnel (A/ULP)-B stated they were unaware they could accept TB test results no earlier than 90 days within the hire date.<br><br>The MDH guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, indicated an employee may begin working with patients with a negative TB history and symptom screen (no symptoms of active TB disease) and a negative serum blood test or the first tuberculin skin test (TST) dated within 90 days before hire.<br><br>The licensee's Tuberculosis Screening/Prevention policy dated March 11, 2024, indicated baseline TB screening at the time of hire was required for all healthcare workers and consisted of three components:<br>-assessing current symptoms of active TB disease;<br>-assessing TB history; and<br>-TB testing for the presence of infection by administering a two-step TB skin test or a single TB blood test.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 660 | | |

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|---|---|---|---|
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| 0 680 | Continued From page 13 | 0 680 | | |
| 0 680 SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(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;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing residents.<br>(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.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to develop a written emergency preparedness (EP) plan with all required content. This had the potential to affect all residents, employees, and visitors to the facility.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a | 0 680 | | |

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|---|---|---|---|---|
| 0 680 | Continued From page 14<br><br>resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On April 28, 2026, at approximately 1:00 p.m., assistant/unlicensed personnel (A/ULP)-B provided a binder labeled Emergency Preparation Plan and stated it was the EP plan for the facility.<br><br>The licensee's EP plan, undated, lacked the following required content:<br>-documentation of annual review of the EP plan and any updates made to the plan based on the review<br>-documentation of quarterly review of missing resident plan;<br>-policy and procedures to address food, water, medical supplies, and pharmaceutical supplies;<br>-policies and procedures to address safe evacuation from the facility, including consideration of care/treatment needs of evacuees, staff responsibilities, transportation, and communication means with external sources of assistance;<br>-policies to address a system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; and<br>-documentation of exercises to test the EP plan at least twice per year, including unannounced staff drills using the EP plan.<br><br>On April 28, 2026, at 2:40 p.m., A/ULP-B stated they had not reviewed or updated the EP plan. A/ULP-B stated they would work with their | 0 680 | | |

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|---|---|---|---|
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|---|---|---|---|---|
| 0 680 | Continued From page 15<br><br>consultant to revise the plan to include all required components.<br><br>The licensee's Emergency Preparedness policy dated March 11, 2024, indicated the licensee would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The policy referenced CMS State Operations Manual Appendix Z; Minnesota Rules 4659.0100.<br><br>The licensee's Missing Resident policy dated March 11, 2024, indicated the missing resident procedure would be reviewed by the director and clinical nurse supervisor at least quarterly and changes to the plan would be documented.<br><br>Minnesota Administrative Rule 4659.0100 dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.72, or successor requirements. This part referenced documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types: Interpretive Guidance."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 680 | | |
| 0 780 SS=F | 144G.45 Subd. 2 (a) (1) Fire protection and physical environment<br><br>(a) Each assisted living facility must comply with | 0 780 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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| 0 780 | Continued From page 16<br><br>the State Fire Code in Minnesota Rules, chapter 7511, and:<br>(1) for dwellings or sleeping units, as defined in the State Fire Code:<br>(i) provide smoke alarms in each room used for sleeping purposes;<br>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;<br>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;<br>(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<br>(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;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.<br><br>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 | 0 780 | | |

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|---|---|---|---|
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| 0 780 | Continued From page 17<br><br>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).<br><br>The findings include:<br><br>Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 30, 2026 for the specific violations related the physical environment under Minnesota Statute 144G.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 0 780 | | |
| 0 800 SS=F | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. | 0 800 | | |

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|---|---|---|---|
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| 0 800 | Continued From page 18<br><br>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).<br><br>The findings include:<br><br>Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 30, 2026 for the specific violations related the physical environment under Minnesota Statute 144G.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 0 800 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b-f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) staff actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(c) Staff of assisted living facilities shall receive | 0 810 | | |

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|---|---|---|---|
| | 36035 | A. BUILDING: _____ B. WING _____ | 04/30/2026 |

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| 0 810 | Continued From page 19<br><br>training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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.<br>(f) Evacuation drills are required for staff 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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.<br><br>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).<br><br>The findings include:<br><br>Please refer to the document titled, Physical | 0 810 | | |

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|---|---|---|---|
| | 36035 | A. BUILDING: _____ B. WING _____ | 04/30/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 0 810 | Continued From page 20<br><br>Environment Inspection Report (PEIR) dated April 30, 2026 for the specific violations related the physical environment under Minnesota Statute 144G.<br><br>TIME PERIOD FOR CORRECTION: Twenty One (21) days. | 0 810 | | |
| 01320 SS=D | 144G.60 Subd. 4 (a) Unlicensed personnel<br><br>(a) Unlicensed personnel providing assisted living services must have:<br>(1) successfully completed a training and competency evaluation appropriate to the services provided by the facility and the topics listed in section 144G.61, subdivision 2, paragraph (a); or<br>(2) demonstrated competency by satisfactorily completing a written or oral test on the tasks the unlicensed personnel will perform and on the topics listed in section 144G.61, subdivision 2, paragraph (a); and successfully demonstrated competency on topics in section 144G.61, subdivision 2, paragraph (a), clauses (5), (7), and (8), by a practical skills test.<br>Unlicensed personnel who only provide assisted living services listed in section 144G.08, subdivision 9, clauses (1) to (5), shall not perform delegated nursing or therapy tasks.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure training and/or competencies were completed and documented for one of two employees (assisted living director in residency/unlicensed personnel (ALDIR/ULP)-C). This had the potential to affect all residents living in the facility. | 01320 | | |

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|---|---|---|---|
| | 36035 | A. BUILDING: _____ B. WING _____ | 04/30/2026 |

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| 01320 | Continued From page 21<br><br>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).<br><br>The findings include:<br><br>ALDIR/ULP-C was hired on May 1, 2025, and began providing assisted living services.<br><br>The licensee's Employee Shift Schedule dated May 2026, indicated ALDIR/ULP-C worked as a caregiver on Saturday and Sunday night shifts from 6:00 p.m. to 7:00 a.m.<br><br>On April 28, 2026, at 9:56 a.m., the surveyor verified ALDIR/ULP-C was not listed on the Minnesota Nurse Aide Registry (NAR).<br><br>ALDIR/ULP-C's personnel record lacked evidence of training and competency evaluations for the following required topics:<br>-standby assistance techniques and how to perform them; and<br>-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.<br><br>On April 28, 2026, at 12:52 p.m., clinical nurse supervisor (CNS)-D was unavailable for an interview.Assistant/ULP (A/ULP)-B stated ALDIR/ULP-C worked independently on weekends at night as a caregiver. A/ULP-B stated | 01320 | | |

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|---|---|---|---|
| | 36035 | A. BUILDING: _____ B. WING _____ | 04/30/2026 |

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| 01320 | Continued From page 22<br><br>that they were not aware ALDIR/ULP-C did not complete all the required competencies.<br><br>The licensee's Staff Competency policy dated March 11, 2024, indicated training and competency evaluations for all unlicensed personnel would include the following topics:<br>-standby assistance techniques and how to perform them; and<br>-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.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01320 | | |
| 01330 SS=D | 144G.60 Subd. 4 (b) Unlicensed personnel<br><br>(b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must:<br>(1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform;<br>(2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or<br>(3) have, before April 19, 1993, completed a training course for nursing assistants that was | 01330 | | |

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|---|---|---|---|
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| 01330 | Continued From page 23<br>approved by the commissioner.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure required training was completed and documented for one of two employees (assisted living director in residency/unlicensed personnel (ALDIR/ULP)-C). This had the potential to affect all residents living in the facility.<br><br>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).<br><br>The findings include:<br><br>ALDIR/ULP-C was hired on May 1, 2025, and began providing assisted living services.<br><br>The licensee's Employee Shift Schedule dated May 2026, indicated ALDIR/ULP-C worked as a caregiver on Saturday and Sunday night shifts from 6:00 p.m. to 7:00 a.m.<br><br>On April 28, 2026, at 9:56 a.m. the surveyor verified ALDIR/ULP-C was not listed on the Minnesota Nurse Aide Registry (NAR).<br><br>ALDIR/ULP-C's personnel record lacked evidence of training and competency evaluations for the following required topics:<br>-safe transfer techniques and ambulation; and | 01330 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| APPLE GROUP HOME INC | 1404 KENTUCKY AVENUE SOUTH SAINT LOUIS PARK, MN 55426 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 01330 | Continued From page 24<br>-range of motion and positioning.<br><br>On April 28, 2026, at 12:52 p.m., clinical nurse supervisor (CNS)-D was unavailable for an interview. Assistant/ULP (A/ULP)-B stated ALDIR/ULP-C worked independently on weekends at night as a caregiver. A/ULP-B stated that they were not aware ALDIR/ULP-C did not complete all the required competencies.<br><br>The licensee's Staff Competency policy dated March 11, 2024, indicated training and competency evaluations for all unlicensed personnel would include the following topics:<br>-standby assistance techniques and how to perform them; and<br>-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.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01330 | | |
| 01460 SS=F | 144G.63 Subdivision 1 Orientation of staff and supervisors<br><br>(a) All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility, except as provided in paragraph (b). | 01460 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 36035 | A. BUILDING: _____ B. WING _____ | 04/30/2026 |

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| 01460 | Continued From page 25<br><br>(b) A staff person is not required to repeat the orientation required under subdivision 2 if the staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of the first facility, or to another facility managed by the same entity managing the first facility. The facility to which the staff person transfers must document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with supplemental orientation specific to the facility and document that the supplemental orientation was provided. The supplemental orientation must include the types of assisted living services the staff person will be providing, the facility's category of licensure, and the facility's emergency procedures. A staff person cannot transfer to an assisted living facility with dementia care without satisfying the additional training requirements under section 144G.83.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure employees received orientation to assisted living facility licensing requirements and regulations with all required content for two of two employees (assisted living director in residence/unlicensed personnel (ALDIR/ULP)-C, clinical nurse supervisor (CNS)-D).<br><br>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 | 01460 | | |

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|---|---|---|---|---|
| 01460 | Continued From page 26<br><br>cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>ALDIR/ULP-C<br>ALDIR/ULP-C was hired on May 1, 2025, and began providing assisted living services.<br><br>The licensee's Employee Shift Schedule dated May 2026, indicated ALDIR/ULP-C worked as a caregiver on Saturday and Sunday night shifts from 6:00 p.m. to 7:00 a.m.<br><br>ALDIR/ULP-C's employee record lacked evidence of training for compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC).<br><br>CNS-D<br>CNS-D was hired on March 11, 2024, and began providing assisted living services.<br><br>CNS-D's employee record included an undated Orientation Checklist with CNS-D's signature. The checklist lacked completion dates for required orientation content.<br><br>CNS-D's employee record lacked documentation that any required orientation content had been completed.<br><br>On April 27, 2026, at 11:36 a.m., during the entrance conference, assistant/unlicensed personnel (A/ULP)-B stated they used Educare (online training program) for orientation and | 01460 | | |

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| 01460 | Continued From page 27<br>training.<br><br>On April 28, 2026, at 12:56 p.m., A/ULP-B stated they were unaware that ALDIR/ULP-C had not completed all required orientation content.<br><br>On April 28, 2026, at 12:56 p.m., CNS-D was unavailable for an interivew. A/ULP-B stated CNS-D was not assigned orientation and did not have an Educare transcript. A/ULP-B stated they thought orientation was not required because CNS-D was a nurse. A/ULP-B stated they would have CNS-D send her Educare transcripts directly to the surveyor.<br><br>On May 4, 2026, at 2:30 p.m. (after the survey was closed), the surveyor received Educare transcripts by email from CNS-D. The transcripts indicated that online training modules had been completed during the survey.<br><br>The licensee's Staff Orientation and Education policy dated December 30, 2024, indicated all employees would attend a general orientation before providing services to residents. The policy indicated orientation topics would include compliance with Minnesota's Vulnerable Adult (sections 626.556 and 5572), including requirements based on organizational policy, identification of incidents of maltreatment (abuse, financial exploitation, and neglect) and that any act that constitutes maltreatment is prohibited.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01460 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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| 01500 | Continued From page 28 | 01500 | | |
| 01500 SS=F | 144G.63 Subd. 5 Required annual training<br><br>(a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include:<br>(1) training on reporting of maltreatment of vulnerable adults under section 626.557;<br>(2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>(3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;<br>(4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;<br>(5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.<br>(b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. | 01500 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 36035 | A. BUILDING: _____ B. WING _____ | 04/30/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 01500 | Continued From page 29<br><br>Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:<br>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;<br>(2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or<br>(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure annual training included all required content and failed to ensure employees received at least eight (8) hours of annual training for each twelve (12) months of employment for two of two employees (assistant/unlicensed personnel (A/ULP)-B, clinical nurse supervisor (CNS)-D).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). | 01500 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 36035 | A. BUILDING: _____ B. WING _____ | 04/30/2026 |

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|---|---|
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| 01500 | Continued From page 30<br>The findings include:<br><br>A/ULP-B<br>A/ULP-B was hired on April 1, 2021, under the licensee's former comprehensive license and began providing assisted living services on August 1, 2021.<br><br>A/ULP-B's employee file included an undated My Transcript indicating annual training had been completed in January 2025. A/ULP-B's My Transcript lacked documentation of required annual training in the following topics:<br>-training on the reporting of maltreatment of vulnerable adults under section 626.557;<br>-review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment; disinfecting environmental surfaces; and reporting communicable diseases; and<br>-the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; and review of the facilities policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures.<br><br>CNS-D<br>CNS-D was hired on March 11, 2024, and began providing assisted living services.<br><br>CNS-D's file lacked annual training for 2025, indicating more than 12 months had passed since annual training was completed.<br><br>On April 28, 2026, at 12:53 p.m., CNS-D was | 01500 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 36035 | A. BUILDING: _____ B. WING _____ | 04/30/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 01500 | Continued From page 31<br><br>unavailabe for an interview. A/ULP-B stated they were aware that their annual training had not yet been completed, and they were "working on it". A/ULP-B stated they were unaware annual training was required for CNS-D because CNS-D was a nurse.<br><br>The licensee's Staff Orientation and Education policy revised on December 30, 2024, indicated all staff providing assisted living services would complete at least 8 hours of education for every 12 months of employment to include the following topics:<br>-reporting of maltreatment of adults;<br>-review of assisted living bill of rights;<br>-review of the organization's policies and procedures related to the provision of assisted living services;<br>-infection control techniques used in the home;<br>-effective approaches to problem solve when working with a resident's challenging behaviors;<br>-the principles of person-centered planning and service delivery and how they apply to direct support services provided by staff; and<br>-mental illness with de-escalation training.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01500 | | |
| 01530 SS=F | 144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De-<br><br>(a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements:<br>(1) supervisors of direct-care staff must have at least eight hours of initial training on dementia | 01530 | | |

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|---|---|---|---|
| | 36035 | A. BUILDING: _____ B. WING _____ | 04/30/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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| 01530 | Continued From page 32<br>topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter;<br>(2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter;<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure dementia, mental illness, | 01530 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 36035 | A. BUILDING: _____ B. WING _____ | 04/30/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 01530 | Continued From page 33<br><br>and de-escalation training was completed within the required timeframe by two of two employees (assisted living director in residence/unlicensed personnel (ALDIR/ULP)-C, clinical nurse supervisor (CNS)-D). Additionally, the licensee failed to ensure that one of two employees (CNS-D) had completed at least two (2) hours of training on topics related to dementia and mental illness for each twelve (12) months of employment thereafter.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>ALDIR/ULP-C<br>ALDIR/ULP-C was hired on May 1, 2025, and began providing assisted living services.<br><br>The licensee's Employee Shift Schedule dated May 2026, indicated ALDIR/ULP-C worked as a caregiver on Saturday and Sunday night shifts from 6:00 p.m., to 7:00 a.m.<br><br>ALDIR/ULP-C's record included a My Transcript (online education) dated April 27, 2026, indicating dementia training had been completed on February 5, 2025, and required mental illness and de-escalation training had been completed on February 6, 2026. ALDIR/ULP-C's transcript indicated dementia, mental illness, and de-escalation training had been completed more | 01530 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 36035 | A. BUILDING: _____ B. WING _____ | 04/30/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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| 01530 | Continued From page 34<br>than 160 hours since ALDIR/ULP-C's date of hire.<br><br>CNS-D<br>CNS-D was hired on March 11, 2024, and began providing assisted living services.<br><br>CNS-D's employee record lacked documentation of initial dementia, mental illness, or de-escalation training. CNS-D's employee record also lacked 2 hours of training on dementia related topics and one hour of training related to topics on mental illness and de-escalation annually.<br><br>On April 28, 2026, at 12:30 p.m., assistant/ULP (A/ULP)-B stated ALDIR/ULP-C had worked 24 hours each weekend since their hire date and had worked more than 160 hours before their dementia training had been completed. A/ULP-B stated they did not assign dementia or mental illness training to CNS-D. A/ULP-B stated they thought CNS-D did not need to completed dementia, mental illness, or de-escalation training because they are a nurse.<br><br>The licensee's Dementia Education policy dated March 11, 2024, indicated direct care employees would complete at least 8 hours of initial education within 160 working hours of employment start date and supervisors would complete at least 8 hours of initial education within 120 hours in the following topics:<br>-an explanation of Alzheimer's disease and other dementias;<br>-assistance with activities of daily living;<br>-problem solving with challenging behaviors<br>-communication skills<br>-person-centered planning and service delivery.<br><br>The licensee's Dementia Education policy dated | 01530 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 36035 | A. BUILDING: _____ B. WING _____ | 04/30/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 01530 | Continued From page 35<br><br>March 11, 2024, also indicated direct care employees and supervisors of direct care staff would complete at least 2 hours of education on topics related to dementia for each 12 months of employment thereafter.<br><br>The licensee's Education on Mental Illness and De-escalation policy dated December 20, 2024, indicated direct care employees would complete at least 2 hours of initial education within 160 working hours of employment start date and supervisors would complete at least 2 hours of initial education within 120 hours in the following topics:<br>-recognizing symptoms of common mental illness diagnoses, including but not limited to mood disorders, anxiety disorders, trauma and stressor related disorders, personality and psychotic disorders, substance abuse disorder and substance misuse;<br>-de-escalation techniques and communication; and<br>-crisis resolution and suicide prevention, including procedures for contacting county crisis response teams and 988 suicide and crisis lifelines.<br><br>The licensee's Education on Mental Illness and De-escalation policy dated December 30, 2024, also indicated direct care employees and supervisors of direct care staff would complete at least 2 hours of education on topics related to mental illness and de-escalation for each 12 months of employment thereafter.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01530 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 36035 | A. BUILDING: _____ B. WING _____ | 04/30/2026 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 01640 | Continued From page 36 | 01640 | | |
| 01640 SS=D | 144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to<br><br>(a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.<br>(b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.<br>(c) The facility must implement and provide all services required by the current service plan.<br>(d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.<br>(e) Staff providing services must be informed of the current written service plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the service plan accurately reflected the current services provided for one of one resident (R1).<br><br>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 | 01640 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| 01640 | Continued From page 37<br><br>a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>R1 was admitted on October 25, 2023, and began receiving assisted living services.<br><br>R1's Service Plan - Modification dated January 28, 2026, indicated R1's services included medication administration, blood pressure monitoring, safety checks, and compression stockings.<br><br>R1's service log dated April 2026, indicated R1 was assisted with compression stockings twice daily.<br><br>On April 28, 2026, at 12:20 p.m., during a phone interview, clinical nurse supervisor (CNS)-D stated they did not recall R1 wearing compression stocking since their hire date in March 2024. CNS-D stated they had forgotten to remove compression stockings from R1's service plan.<br><br>The licensee's Service Plan policy dated March 11, 2024, indicated service plans would be revised based on resident review or reassessment. The policy also indicated the initial service plan and any revisions would be signed by a representative from the licensee and the resident or resident's representative, indicating agreement with the services to be provided.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01640 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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|---|---|---|---|---|
| 01650 | Continued From page 38 | 01650 | | |
| 01650 SS=F | 144G.70 Subd. 4 (f) Service plan, implementation and revisions to<br><br>(f) The service plan must include:<br>(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;<br>(2) the identification of staff or categories of staff who will provide the services;<br>(3) the schedule and methods of monitoring assessments of the resident;<br>(4) the schedule and methods of monitoring staff providing services; and<br>(5) a contingency plan that includes:<br>(i) the action to be taken if the scheduled service cannot be provided;<br>(ii) information and a method to contact the facility;<br>(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<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the resident service plan included the required content for three of three residents (R1, R2, R3). | 01650 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 36035 | A. BUILDING: _____ B. WING _____ | 04/30/2026 |

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|---|---|---|---|---|
| 01650 | Continued From page 39<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>R1<br>R1 was admitted on October 25, 2023, and began receiving assisted living services.<br><br>R1's Service Plan Modification signed on January 28, 2026, indicated R1 received services including assistance with medication administration, blood pressure monitoring, safety checks, and compression stockings.<br><br>R2<br>R2 was admitted on May 22, 2023, and began receiving assisted living services.<br><br>R2's Service Plan Modification signed on January 28, 2026, indicated R2's services included assistance with activities, symptom management, and medication administration.<br><br>R3<br>R3 was admitted on June 20, 2023, and began receiving assisted living services.<br><br>R3's Service Plan Modification signed on January 28, 2023, indicated R3's services included medication administration and behavior management. | 01650 | | |

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| 01650 | Continued From page 40<br><br>R1, R2, and R3's service plans lacked the following required content:<br>-fees for services provided;<br>-the schedule and methods of monitoring assessments of the residents;<br>-the schedule and methods of monitoring staff providing services; and<br>-a contingency plan that includes the actions to be taken if the scheduled service cannot be provided.<br><br>On April 27, 2026, at 2:16 p.m., clinical nurse supervisor (CNS)-D stated there was a version of the service plan in their electronic system that they were not using, and she was unable to access the expanded version of the service plan.<br><br>The licensee's Service Plan policy dated March 11, 2024, indicated service plans would include the following information:<br>-the fees for services and the frequency of each service according to the residents' current assessment and resident preferences;<br>-the schedule and method of monitoring reviews or assessments of the resident;<br>The schedule and method of monitoring staff providing services; and<br>-a contingency plan that includes the action to be taken if the scheduled service cannot be provided.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01650 | | |
| 01730 SS=E | 144G.71 Subd. 5 Individualized medication management plan | 01730 | | |

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| 01730 | Continued From page 41<br>(a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following:<br>(1) a statement describing the medication management services that will be provided;<br>(2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;<br>(3) documentation of specific resident instructions relating to the administration of medications;<br>(4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;<br>(5) identification of medication management tasks that may be delegated to unlicensed personnel;<br>(6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and<br>(7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.<br>(b) The medication management record must be current and updated when there are any changes.<br>(c) Medication reconciliation must be completed | 01730 | | |

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| 01730 | Continued From page 42<br>when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to develop an individualized medication management record with the required content for two of three residents (R2, R3).<br><br>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 resident's are affected, more than a limited number of staff are involved or the situation has occurred repeatedly, but is not found to be pervasive).<br><br>The findings include:<br><br>R2<br>R2 was admitted on May 22, 2023, and began receiving assisted living services.<br><br>R2's Service Plan Modification signed on January 28, 2026, indicated R2's services included assistance with activities, symptom management, and medication administration.<br><br>R3<br>R3 was admitted on June 20, 2023, and began receiving assisted living services.<br><br>R3's Service Plan Modification signed on January | 01730 | | |

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| 01730 | Continued From page 43<br><br>28, 2023, indicated R3's services included medication administration and behavior management.<br><br>R2 and R3's individualized medication management plans lacked identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis.<br><br>On April 27, 2026, at 1:30 p.m., the surveyor observed owner/unlicensed personnel (O/ULP)-A administering medications to R2.<br><br>On April 28, 2926, at 8:30 a.m., the surveyor observed O/ULP-A administering medications to R3.<br><br>On April 28, 2026, at 2:39 p.m., clinical nurse supervisor (CNS)-D was unavailable for an interview. Assistant/ULP (A/ULP)-B stated they were unaware that the medication management plans for R2 and R3 were missing content and would pass the information along to the nurse.<br><br>The licensee's Service Plan for Medication Management policy dated March 11, 2024, indicated medication management plans would include identification of persons responsible for monitoring medication supplies and ensuring refills are ordered/timely.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01730 | | |
| 01760 SS=F | 144G.71 Subd. 8 Documentation of administration of medication | 01760 | | |

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| 01760 | Continued From page 44<br><br>Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure unlicensed personnel (ULP) followed the proper steps of the medication administration process for two of two residents (R2, R3).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>R2<br>On April 27, 2026, at 1:30 p.m., owner/unlicensed personnel (O/ULP)-A was observed administering medications to R2. R2's medication was | 01760 | | |

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| 01760 | Continued From page 45<br><br>pre-packaged in bubble packs from the pharmacy. The names and instructions for all medication were listed on the package. O/ULP-A did not reference a medication administration record (MAR), to ensure the medications were accurate, before administration.<br><br>R2 was admitted on May 22, 2023, and began receiving assisted living services.<br><br>R2's Service Plan Modification signed on January 28, 2026, indicated R2's services included assistance with activities, symptom management, and medication administration.<br><br>R3<br>On April 28, 2026, at 8:31 a.m., O/ULP-A was observed administering medications to R3. R3's medication was pre-packaged in bubble packs from the pharmacy. The names and instructions for all medication were listed on the package. O/ULP-A did not reference a medication administration record (MAR), to ensure the medications were accurate, before administration.<br><br>R3 was admitted on June 20, 2023, and began receiving assisted living services.<br><br>R3's Service Plan Modification signed on January 28, 2023, indicated R3's services included medication administration and behavior management.<br><br>On April 28, 2026, at 8:50 a.m., O/ULP-A stated he knew what medications the residents were given, and he would check and sign them off on the computer after giving them.<br><br>On April 28, 2026, at 12:21 p.m., during a phone | 01760 | | |

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| 01760 | Continued From page 46<br><br>interview, clinical nurse supervisor (CNS)-D stated that staff were trained to check medications prior to administration. CNS-D stated they could check medications on the computer (located on the lower level) or on their phones.<br><br>The licensee's Medication Administration policy dated March 11, 2024, indicated all staff with responsibility for medication administration would have access to information about the medication being administered to include purpose, dosage, frequency, route, and instructions related to the medication and specific to the residents.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01760 | | |
| 01880 SS=F | 144G.71 Subd. 19 Storage of medications<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to store all medications in a securely locked location when medications were left unattended for one of one resdient (R1).<br><br>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 | 01880 | | |

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| 01880 | Continued From page 47<br><br>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).<br><br>The findings include:<br><br>On April 27, 2026, at 11:38 a.m., owner/unlicensed personnel (O/ULP)-A stated they provided medication management and administration assistance to all three residents.<br><br>R3 was admitted on June 3, 2023, and began receiving assisted living services.<br><br>R3's Service Plan Modification signed on January 28, 2026, indicated R3's services included medication administration.<br><br>R3's Individualized Medication Management Plan completed on February 8, 2026, indicated staff would administer R3's medications. THe plan also indicated R3's medications would be stored in a locked closet.<br><br>R3's Medication Administration Summary dated April 2026, indicated R3 had been administered fluticasone 50 microgram (mcg) nasal spray daily.<br><br>On April 28, 2026, at 11:15 a.m., during a facility tour, the surveyor observed a bottle of fluticasone nasal spray on R3's bedside table.<br><br>On April 28, 2026, at 11:15 a.m., O/ULP-A picked up the bottle and stated the fluticasone should be locked in the medication closet.<br><br>On April 28, 2026, at 12:20 p.m., during a telephone interview, clinical nurse supervisor (CNS)-D stated medications should not be kept at | 01880 | | |

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| 01880 | Continued From page 48<br><br>the bedside and should be stored in the locked medication closet.<br><br>The licensee's Storage/Control of Medications policy dated March 11, 2024, indicated all prescription medications were securely locked in substantially constructed compartments according to the manufacturer's directions and only authorized personnel would have access to the stored medication.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01880 | | |

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

# Food & Beverage Inspection Report



## Establishment Info

Apple Group Home Inc
1404 Kentucky Ave S
St Louis Park, MN 55426
Hennepin County
Parcel:

Phone:

## License Info

License: HFID 36035

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

## Inspection Info

Report Number: F1013261023
Inspection Type: Full - Single
Date: 4/27/2026 Time: 12:50 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 2
Total Priority 3 Orders: 1
Delivery:

**New Order: 3-500C Microbial Control: date marking**
3-501.17B *Priority Level: Priority 2 CFP#: 23*
*MN Rule 4626.0400B* Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.
COMMENT: 4/27/26 REPEAT
READY-TO-EAT PACKAGES OF COMMERCIALLY PROCESSED CUT MELON (WATER MELON AND CANTALOUPE) WERE IN THE KITCHEN REFRIGERATOR WITHOUT A DATE MARK. PER STAFF THE FOODS WERE OPENED 3 DAYS PRIOR. COMPLY WITH RULE. DISCUSSED DATE MARK PROCEDURES AND STAFF DATE MARKED THE FOOD. ORDER WAS ISSUED ON 12/11/23.
*Comply By: Complied On Site Originally Issued On: 4/27/2026*

**New Order: 4-200 Equipment Design and Construction**
4-201.11GMN *Priority Level: Priority 3 CFP#: 47*
*MN Rule 4626.0506G* Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.
COMMENT: COOKED FOOD (CHICKEN, BEANS) WERE HELD COLD IN THE REFRIGERATOR. PER STAFF THE FOOD WAS PURCHASED FOR RESIDENTS ON THE DAY PRIOR. COMPLY WITH RULE. DISCUSSED SAME DAY SERVICE AND FOOD WAS DISCARDED.
*Comply By: 4/27/2026 Originally Issued On: 4/27/2026*

**New Order: 4-300 Equipment Numbers and Capacities**
4-302.13B *Priority Level: Priority 2 CFP#: 48*
*MN Rule 4626.0710B* Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.
COMMENT: FACILITY HAS A HOT WATER SANITIZING DISH MACHINE. NO TEST KIT MEETING THE ABOVE REQUIREMENT WAS AVAILABLE. COMPLY WITH RULE. DISCUSSED TEST KIT USE AND PROVIDED A TEST STRIP.
*Comply By: 5/1/2026 Originally Issued On: 4/27/2026*

! **New Order: 4-700 Sanitizing Equipment and Utensils**
4-702.11 *Priority Level: Priority 1 CFP#: 16*
*MN Rule 4626.0900* Sanitize utensils and food contact surfaces of equipment before use, after cleaning.
COMMENT: 4/27/26 REPEAT
STAFF WASHED WARE WITH SOAP. NO SANITIZER USED FOR PLATES AND CUPS AIR DRYING NEAR SINK. COMPLY WITH RULE. DISCUSSED WARE WASHING PROCEDURES WITH STAFF AND WARE WILL BE WASHED IN THE DISH MACHINE. ORDER WAS ISSUED ON 12/11/23.
*Comply By: 4/27/2026 Originally Issued On: 4/27/2026*

# Food & Beverage General Comment

The inspection was completed with MDH G. Stark and the operator then reviewed with MDH Nurse Evaluator M. Winters.

The establishment has a residential kitchen. Food must be served on day of service. The kitchen has painted wood cabinets, vinyl plank floor, smooth painted walls, laminate counter top, and a smooth painted ceiling.

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

Residential dish machine is available to wash ware. The dish machine should be run on the sanitize/high temperature cycle.

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

**NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.**

**I acknowledge receipt of the Metro District Office inspection report number F1013261023 from 4/27/2026**

Nuh Ahmed
Operator

Jerry Malloy

Jerry Malloy,
Public Health Sanitarian Supervisor
651-201-3998
jerry.malloy@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

# Temperature Observations/Recordings



## Establishment Info

Apple Group Home Inc
St Louis Park
County/Group: Hennepin County

## Inspection Info

Report Number: F1013261023
Inspection Type: Full
Date: 4/27/2026
Time: 12:50 PM

**Food Temperature: Product/Item/Unit:** Watermelon**; Temperature Process:** Cold-Holding
**Location:** Refrigerator at 39 Degrees F.
Comment:
*Violation Issued?: No*

**Food Temperature: Product/Item/Unit:** Chicken**; Temperature Process:** Cold-Holding
**Location:** Refrigerator at 37 Degrees F.
Comment:
*Violation Issued?: No*

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

# Sanitizer Observations/Recordings



## Establishment Info

Apple Group Home Inc
St Louis Park
County/Group: Hennepin County

## Inspection Info

Report Number: F1013261023
Inspection Type: Full
Date: 4/27/2026
Time: 12:50 PM

**Sanitizing Equipment:** **Product:** Hot Water**; Sanitizing Process:** Dish Machine
**Location:** Kitchen **Equal To** 170 Degrees F.
Comment:
*Violation Issued?: No*

# Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

| | |
|---|---|
| **Project No:** SL36035016 | **Date:** 4/30/2026 |
| **Facility Name:** Apple Group Home Inc. | |
| **Facility Address:** 1404 Kentucky Ave S, St Louis Park, MN 55426 | |

☒ **TAG IDENTIFICATION: 0780**

**SCOPE/ SEVERITY:** Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Smoke alarms shall be interconnected so that actuation of one alarm causes all alarms in the individual dwelling or sleeping unit to operate where more than one smoke alarm is required within an individual dwelling or sleeping unit. [Minn. Stat. 144G.45 subd.2]

   *Comments: The smoke alarms installed throughout the building were not properly interconnected. Smoke alarms should be interconnected such that the activation of any alarm causes all other smoke alarms to sound. Smoke alarms indicated manufacture date in 2002 and exceeded 10 years from manufacture. Smoke alarms should be replaced when they exceed 10 years in age and should be replaced with non-expired alarms.*

☒ **TAG IDENTIFICATION: 0800**

**SCOPE/ SEVERITY:** Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. [Minn. Stat. 144G.45 subd.2]

   *Comments:*

   *The crank on the bedroom window in resident room 2 was damaged and should be repaired.*

*There was a dark moldlike substance around the window frame, on the ceiling and on the tiles around the bathtub in the bathroom. Evidence of water damage and moisture was present. The surfaces in the bathroom should be cleaned to remove the dark substance, and the bathroom should be maintained free of staining or dirt.*

*The protective globe on the light fixture in resident room 4 was missing and should be replaced.*

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☒ **TAG IDENTIFICATION: 0810**

**SCOPE/ SEVERITY:** Level 2; Widespread

**TIME PERIOD OF CORRECTION:** Twenty One (21) days

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1. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

   *Comments: Licensee failed to provide adequate documentation of employee actions for evacuation to the surveyor during survey. General information was provided but no site-specific procedures were present in the FSEP. Further documentation was emailed to the surveyor later but was not accurate or complete.*

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

   *Comments: No documentation of resident actions for evacuation were provided to the surveyor during survey. Site-specific resident actions for evacuation should be created and stored in the FSEP.*

3. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

   *Comments: No records of staff trainings on the FSEP were provided to the surveyor during survey. The licensee indicated that no trainings had been recorded. Staff should receive training upon hire and twice a year thereafter on the FSEP.*

4. 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. [Minn. Stat. 144G.45 subd.2]

   *Comments: No records of resident trainings on the FSEP were provided to the surveyor during survey. Residents should be offered training on the FSEP at least once a year.*