Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

March 2, 2026

Licensee
Valley Assisted Living
523 Arnold Avenue South
Thief River Falls, MN 56701

RE: License Number 418408
Health Facility Identification Number (HFID) 30224
Project Number(s) SL30224016

Dear Licensee:

On January 8, 2026, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed July 16, 2025. The follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective January 8, 2026.

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.

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

Sincerely,

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

JMD

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

October 22, 2025

Licensee
Valley Assisted Living
523 Arnold Avenue South
Thief River Falls, MN 56701

RE: Conditional License Number 418408
Health Facility Identification Number (HFID) 30224
Project Number(s) SL30224016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 16, 2025, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, Subd. 1(a), MDH is issuing a 90-day conditional license, pending appeal under Minn. Stat. § 144G.20, Subd. 18.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH documents state 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 addtion to any enforcement mechanism authorized in § 144G.20.

St - 0 - 0110 - 144g.10 Subdivision 1a - Assisted Living Director License Required - $1,000.00
St - 0 - 0420 - 144g.40 Subdivision 1 - Responsibility For Housing And Services - $1,000.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $1,000.00

Therefore, the total amount you are assessed is $3,000.00. You will be invoiced approximately 30 days after receipt of this notice, pending 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 and immediately correct any reissued orders 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. If you request a hearing, please specify whether you are appealing the orders and fines, the imposed conditions, or both.

CONDITIONAL LICENSE ISSUED:
MDH will issue Valley Assisted Living a conditional assisted living facility license for 90 calendar days, pending appeal. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Valley Assisted Living is in substantial compliance.

The following conditions apply on the conditional assisted living facility license:

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.

b. **No new admissions:** Valley Assisted Living will not admit any new residents under its conditional assisted living facility license until MDH removes the "no new admissions" condition. Valley Assisted Living must provide the Department:

    i. A list of the names and birthdates of any individuals Valley Assisted Living is currently in the process of admitting. These individuals will be able to continue the admittance process.

    ii. A list of all current residents:
        1. Name and birthdate of each resident
        2. Current payment source for services
        3. If Elderly Waiver, the name and contact information of the care coordinator/case manager
        4. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

c. **Consultant:** Valley Assisted Living will contract with an RN to provide consultation concerning all resident(s) to whom Valley Assisted Living provides licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from Valley

Assisted Living. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH. The RN must not have any affiliation with Valley Assisted Living and MDH must review the RN's credentials and approve the selection. Valley Assisted Living is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Valley Assisted Living in an effort to help Valley Assisted Living align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. Valley Assisted Living will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements.

d. Reports: The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Valley Assisted Living and the RN consultant about a change. Each report will be electronically submitted to: **HRDConsultantReports.MDH@state.mn.us**. The content of the reports will include information such as:

i. Progress towards correction of orders;
ii. Observations of staff delivering assisted living services and the level of competency observed;
iii. Conversations with residents and family members about satisfaction with assisted living services;
iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
v. Overall impressions about the quality of the assisted living services delivered;
vi. Overall impressions about the dignity with which the residents and their family members are treated;
vii. Concerns; and
viii. Any other information requested by the Department or considered important by the RN consultant(s).

e. Monitoring visits: MDH may make unannounced monitoring visits to assess the progress of Valley Assisted Living to correct the violations cited during the survey as well as to determine the overall practice of Valley Assisted Living in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.

f. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.

g. **Corrective Action Plan:** Valley Assisted Living will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
   i. A statement of the concern
   ii. A description of what will happen to correct the concern
   iii. A target date for when each correction will be complete
   iv. Who is responsible to make sure it happens
   v. Current status of correction work
   vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:
MDH will determine if Valley Assisted Living is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Valley Assisted Living is in substantial compliance on the follow up survey, MDH will remove the conditions from Valley Assisted Living's assisted living facility license, and Valley Assisted Living will correct any outstanding violations identified during the survey. If Valley Assisted Living is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING A HEARING:
Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action.

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

If you request a hearing, please specify whether you are appealing the correction orders and assessed fines, the imposed conditions, or both.

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 Jessie Chenze directly at: 218-332-5175.

Sincerely,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager
Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30224	A. BUILDING: _____ B. WING _____	07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY ASSISTED LIVING	523 ARNOLD AVENUE SOUTH THIEF RIVER FALLS, MN 56701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ***ATTENTION*** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30224016-0 ****AMENDED**** After further review of building plans, Vally Assisted Living does in fact have a 2-hour fire barrier between the childcare center and the assisted living area as required by 144G.10, Subdivision 1. Therefore, the 0100 tag is rescinded. On July 14, 2025, through July 16, 2025, 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 15 residents; 15 receiving services under the Assisted Living Facility with Dementia Care license. An immediate correction order was identified on	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 000	Continued From page 1 July 16, 2025, issued for SL30224016-0, tag identification 0110. The licensee took action on July 16, 2025, to mitigate the risk; however, the scope and level remains at level 3/Widespread (I). An immediate correction order was identified on July 16, 2025, issued for SL30224016-0, tag identification 1290. The licensee took action on July 16, 2025, to mitigate the risk; however, the scope and level remains at level 3/Widespread (I).	0 000		
0 110 SS=I	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director who is licensed or permitted by the Board of Executives for Long Term Services and Supports and affiliated as the director of record with the board. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employment of a licensed assisted living director (LALD), licensed by the Board of Executives for Long Term Services and Supports (BELTSS). This had the potential to affect all residents and staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when	0 110		

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0 110	Continued From page 2 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: This resulted in an immediate correction order issued on July 16, 2025. The licensee held an assisted living facility with dementia care (ALFDC) license issued on November 1, 2024, through October 31, 2025. During the entrance conference on July 14, 2025, at 10:44 a.m., consultant (C)-C stated previous (P)LALD-O was listed as the current LALD for the licensee and PLALD-O had worked for the license through the previous management company that is no longer affiliated with the licensee. On July 14, 2025, at 11:22 a.m., the BELTSS website indicated PLALD-O was listed as the director of record for the facility effective October 9, 2024. On July 14, 2025, at 1:06 p.m., clinical nurse supervisor (CNS)-B stated PLALD-O was no longer employed with the licensee and administrator (A)-N was going to be the LALD for the licensee. On July 15, 2025, at 9:48 a.m., administrative assistant (AA)-A stated AA-A had never met or seen PLALD-O in the building or spoke with PLALD-O since AA-A started in January 2025. On July 14, 2025, at 1:37 p.m., the BELTSS website indicated C-C was listed as the director	0 110		

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0 110	Continued From page 3 of record for the licensee effective June 8, 2025, and expired July 1, 2025. On July 14, 2025, at 1:40 p.m., the BELTSS website indicated A-N had a shared residency permit effective October 10, 2023, and expired October 9, 2024, for the licensee. On July 14, 2025, at 1:42 p.m., C-C stated C-C was going to be LALD mentor for A-N, however, A-N's BELTSS application was denied, and the licensee was in the process of completing an appeal with BELTSS. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 110		
0 420 SS=I	144G.40 Subdivision 1 Responsibility for housing and services The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide sufficient management, control, and operation of the housing and services provided by the facility. This had the potential to affect all residents. This practice resulted in a level three violation (a	0 420		

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0 420	Continued From page 4 violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 14, 2025, at 10:47 a.m., consultant (C)-C stated the licensee was familiar with the current minimum assisted living requirements. The licensee held an assisted living license with dementia care license effective November 1, 2024, with an expiration date of October 31, 2025. The licensee's renewal "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified an affirmative checkmark next to the statement, "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659, governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." Another checkmark was noted at the statement, "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements	0 420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 420	Continued From page 5 related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH (Minnesota Department of Health), in writing, of any changes to this information as required." Page six was electronically signed by the owner/authorized agent on October 1, 2024. As a result of this survey, the following orders were issued under 0100, 0110, 0470, 0480, 0490, 0640, 0650, 0660, 0680, 0775, 0800, 0810, 0830, 1290, 1460, 1500, 1540, 1550, 1620, 1710, 1760, 1770, 1790, 1820, 1880, 1930, 1940, 1950, 1960, 1970, 2040, and 2320, which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 420		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies	0 470		

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0 470	Continued From page 6 and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the clinical nurse supervisor (CNS) developed and implemented a staffing plan to determine staffing levels to meet the needs of all residents. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living license with	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 470	Continued From page 7 dementia care license effective November 1, 2024, with an expiration date of October 31, 2025. The facility was licensed for a capacity of 43 and had a current census of 15 residents. During the entrance conference on July 14, 2025, at 10:47 a.m., consultant (C)-C stated the licensee was familiar with the current minimum assisted living requirements. On July 14, 2025, at 1:10 p.m., CNS-B stated the licensee scheduled the following unlicensed personnel (ULPs) for each shift: -day shift 7:00 a.m. through 2:00 p.m., two ULPs were scheduled; -evening shift 2:00 p.m. through 10:00 p.m., one ULP was scheduled; and -night shift 10:00 p.m. through 7:00 a.m., one ULP was scheduled. On July 16, 2025, at 5:28 a.m., C-C emailed (electronic mail) C-C spoke with the previous management company and confirmed a staffing plan had not been completed. On July 16, 2025, at 1:03 p.m., CNS-B stated CNS-B was not sure if a staffing plan had been developed, and CNS-B was not aware of the staffing plan requirement. CNS-B further stated administrator (A)-N was responsible for the licensee's staffing needs and scheduling of staff. No further information was provided. 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		

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
VALLEY ASSISTED LIVING	523 ARNOLD AVENUE SOUTH THIEF RIVER FALLS, MN 56701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 480	Continued From page 8 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (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; (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; (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; (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; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A,	0 480		

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	30224	A. BUILDING: _____ B. WING _____	07/16/2025

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VALLEY ASSISTED LIVING	523 ARNOLD AVENUE SOUTH THIEF RIVER FALLS, MN 56701

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0 480	Continued From page 9 existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (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 (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 14, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24	0 480		

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0 480	Continued From page 10 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 490 SS=F	144G.41 Subdivision 1b Minimum requirements; other required services All assisted living facilities must offer to provide or make available the following services to residents: (1) weekly housekeeping; (2) weekly laundry service; (3) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (4) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (5) provide culturally sensitive programs; and (6) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have daily programs	0 490		

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0 490	Continued From page 11 of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs. This had the potential to affect all 15 residents at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 14, 2025, at 10:53 a.m., consultant (C)-C stated to C-C's understanding the licensee had provided a daily program of social and recreational activity for residents. During a self-guided tour on July 14, 2025, from 12:05 p.m. until 12:15 p.m., the surveyor observed a bulletin board hanging in the hallway. The sign on the bulletin board indicated activities, then listed bingo on Thursday's at 3:00 p.m. with volunteers, and Sunday's at 2:00 p.m. with an unknown individual. No other activities were posted on the bulletin board. During the survey on July 14, 2025, through July 16, 2025, the surveyor did not observe any planned or offered activities for residents to attend. The surveyor observed residents sitting in the hallway or watching television in the dining room, while some residents remained in their rooms most of the day.	0 490		

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0 490	Continued From page 12 On July 15, 2025, at 9:35 a.m., administrative assistant (AA)-A stated the licensee did not have an activity coordinator, nor had the licensee developed an activity calendar. AA-A stated the licensee was doing the best to provide an activity such as bingo or offer a church service. On July 16, 2025, at 12:58 p.m., clinical nurse supervisor (CNS)-B stated the licensee use to have an activity calendar posted in the kitchen, however, the kitchen was under construction and not accessible by residents or staff. CNS-B further stated administration was working on an activities program for residents and the licensee's activity program was "poor." CNS-B further stated CNS-B was new to the CNS role and was using the survey process for an opportunity to learn. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 490		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language.	0 640		

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0 640	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post required content in common areas to include posting the 911 emergency number in common areas at the assisted living. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During a self-guided tour on July 14, 2025, from 12:05 p.m., until 12:15 p.m., the surveyor did not observe 911 posted in any common areas of the assisted living. On July 15, 2025, at 6:16 a.m., unlicensed personnel (ULP)-F stated 911 was posted on the bulletin board in the ULP/nurse office, however, ULP-F stated residents or visitors would not be able to observe the 911 posting. On July 15, 2025, at 9:35 a.m., administrative assistant (AA)-A stated the licensee only posted the 911 number in the ULP/nurse office that was not accessible by any residents or visitors. The licensee's Required Postings in Licensed Assisted Living Policy dated February 2022,	0 640		

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0 640	Continued From page 14 indicated 911 Emergency [sic] number in common areas near telephones would be posted in a conspicuous place. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (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, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by:	0 650		

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0 650	Continued From page 15 Based on interview and record review, the licensee failed to ensure employee records contained the required content for one of two employees (registered nurse (RN)-D). This practice resulted in a level two violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on July 14, 2025, at 11:32 a.m., consultant (C)-C stated C-C was aware of required contents in an employee record. RN-D was hired on August 21, 2018, and provided direct care and RN on call services for supervision to residents and staff at the assisted living effective August 1, 2021. RN-D's employee record lacked annual performance reviews, and a job description. On July 16, 2025, at 1:08 p.m., clinical nurse supervisor (CNS)-B stated the licensee was behind on scanning paper documents into employee records and the license likely had RN-D's annual performance review and job description filled out on paper, however, CNS-B was unable to locate. On July 16, 2025, at 9:34 a.m., C-C stated C-C had provided the surveyor with all the licensee's	0 650		

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0 650	Continued From page 16 documentation C-C was able to locate. The licensee's Employee Required Documents policy dated March 22, 2022, indicated employee records included a current job description, including qualifications, responsibilities, and identification of staff persons providing supervision. In addition, employee records included documentation of annual performance reviews that identify areas of improvement needed and training needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (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 covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	0 660		

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0 660	Continued From page 17 Based on observation, 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) and Minnesota Department of Health (MDH), including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of two employees (unlicensed personnel (ULP)-H). This practice resulted in a level two violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on July 14, 2025, at 10:47 a.m., consultant (C)-C stated the licensee was familiar with the current minimum assisted living requirements. The licensee's Facility TB Risk Assessment Worksheet for Health Care Settings Licensed by MDH was completed on May 31, 2025, and the facility was determined to be a low risk level. ULP-H was hired on April 30, 2025, to provide direct care services to residents at the assisted living with dementia care facility. On July 15, 2025, at 3:57 p.m., the surveyor observed ULP-H provide scheduled afternoon medication administration for R6.	0 660		

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0 660	Continued From page 18 ULP-H's employee record contained a negative Baseline TB Screening Tool for Healthcare Workers (HCWs) dated June 20, 2025. ULP-H's employee record lacked evidence of completion of a two-step TST or other evidence of TB screening such as a blood test. On July 16, 2025, at 1:22 p.m., clinical nurse supervisor (CNS)-B stated ULP-H was supposed to have completed a two-step TST upon hire, however, the licensee was aware ULP-H had not completed a two-step TST. CNS-B further stated the license previously administered two-step TST at the facility, however, the licensee could no longer obtain tuberculin to complete the two-step TSTs and referred new employees to go to the local clinic to complete the two-step TST. The licensee's TB and Staff Screening policy dated June 2021, indicated new staff shall have a two-step TST conducted with results document on the Baseline TB Screening Tool for HCWs. In addition, a blood test shall be an acceptable substitute for a two-step TST. The Regulations for TB Control in Minnesota Health Care Settings dated July 2013, indicated a baseline TB screening is required for all HCWs upon hire, and included administering a two-step TST or single blood draw to screen for active TB. The MDH TB Screening and Education Requirements for Assisted Living Facilities and Home Care Providers dated February 3, 2022, indicated baseline TB screening is required at the time of hire for all health care personnel in Minnesota. Baseline TB screening includes	0 660		

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0 660	Continued From page 19 assessing for current symptoms of active TB disease; assessing TB history; and testing for the presence of infection with Mycobacterium TB by administering either a two-step TB skin test or a single TB blood test. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.	0 680		

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0 680	Continued From page 20 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and post a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. In addition, the licensee failed to ensure the missing resident plan was reviewed quarterly. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 14, 2025, at 10:47 a.m., consultant (C)-C stated the licensee was familiar with the current minimum assisted living requirements. During a self-guided tour on July 14, 2025, from 12:05 p.m. until 12:15 p.m., the surveyor did not observe signage posted in any common areas of the assisted living of where to locate the licensee's EPP. The licensee's electronic EPP dated June 1, 2024, signed by administrator (A)-N, lacked the following content and/or policies and procedures to address:	0 680		

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0 680	Continued From page 21 - an EPP available for all staff, residents, and volunteers to access; - annual review of the EPP; - a missing resident plan that was reviewed quarterly: Missing Resident policy provided was reviewed January 2024, July 2024, and July 2025, respectively; - a description of the population served by the licensee; - the medical record documentation system the facility has developed to preserve resident information security and availability of records; - memorandums of agreement (MOAs) with other facilities; and - must conduct exercises to test the EPP at least twice per year, including unannounced staff drills using the EPP. On July 15, 2025, at 6:16 a.m., unlicensed personnel (ULP)-F stated the licensee had no signage posted for the licensee's EPP and ULP-H had thought the EPP was kept in the office. On July 15, 2025, at 8:25 a.m., C-C stated C-C was not sure if an EPP binder was accessible for residents, staff, or visitors. On July 15, 2025, at 9:34 a.m., administrative assistant (AA)-A stated the licensee did not post any EPP signage of where the EPP binder was located. AA-A further stated AA-A found the EPP binder in front of the nurse's office, however, AA-A stated it (EPP binder) was old and from 2019. On July 15, 2025, at 9:57 a.m., AA-A stated AA-A had never done anything with the licensee's EPP and AA-A was not sure who was responsible for	0 680		

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0 680	Continued From page 22 reviewing and updating the EPP annually. AA-A further stated AA-A was not sure how often the missing resident was reviewed or if the licensee had completed any test exercises. AA-A stated AA-A was not sure how staff, residents, or visitors would access the current EPP if it was stored on a computer or online. AA-A further stated AA-A had recalled the licensee had discussed MOAs, however, AA-A was not sure where the MOAs were located. On July 16, 2025, at 9:34 a.m., C-C stated C-C had provided the surveyor with all the licensee's documentation C-C was able to locate. On July 16, 2025, at 12:48 p.m., clinical nurse supervisor (CNS)-B stated CNS-B was not sure who was responsible for the EPP, however, CNS-B had thought it was the responsibility of the administration. The licensee's Emergency Preparedness Program dated July 2025, indicated the facility will develop a facility-specific emergency plan to be activated according to its emergency threat and will review it (EPP) annually. In addition, training will occur minimally each year and the facility must conduct exercises to test the emergency plan at least twice per yea, including unannounced staff drills using the emergency procedures. The licensee's Missing Resident policy dated July 2025, did not address how often the policy would be reviewed. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110, Subp. 4, effective October 2022, the assisted living director and clinical	0 680		

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0 680	Continued From page 23 nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	0 800		

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0 800	Continued From page 24 Based on observation and interview, the licensee failed to maintain 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 addition, the licensee failed to comply with Minnesota State Fire Code in Minnesota Rules chapter 7511. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 15, 2025, at 1:45 p.m., surveyor toured the facility with construction consultant (CC)-R. The following was observed: GENERAL MAINTENANCE: Office window had an air conditioner installed and was missing the weather proofing strips along the side leaving it exposed to the outside. Resident room (unoccupied) #11 had the wood finishes coming off the closet door. Resident room (Occupied) #14 had holes in the carpet.	0 800		

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0 800	Continued From page 25 Resident room (unoccupied) #15 was under construction due to water damage done to the ceiling. CC-R stated they understood the above-listed deficiencies. Electrical Hazards: On August 5, 2025, at 10:30 a.m., it was observed that there was a portable space heater that was being powered through an extension cord resident room #13. The plug end of the extension cord had been replaced from the original manufacturer plug end. Space heaters shall only be used in nonsleeping staff and employee areas. Extension cords shall be maintained in good condition without splices, deterioration or damage. Ammunition components storage: On August 5, 2025, at 10:30 a.m., a 100-count box of large rifle primers was observed on top of a folding table in resident room #13. The storage of black powder, smokeless propellants, and small arms primers is prohibited. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping	0 810		

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0 810	Continued From page 26 rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors.	0 810		

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0 810	Continued From page 27 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 15, 2025, at 2:50 p.m. consultant (C)-C was unable to provide documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. C-C stated that she understood the requirements of maintaining this plan. TRAINING: The licensee failed to provide evacuation training to staff and residents as required. C-C stated that she understood the requirements for training the employees and residents. DRILLS: The licensee failed to conduct evacuation drills for employees as required. C-C stated that she understood the requirements for employees conducting evacuation drills twice per year per shift with at least one evacuation drill every other month. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation, record review and interview, the licensee failed to comply with all state and local governing laws, and codes for fire safety, building, and zoning requirements. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 15, 2025, at 2:30 p.m., survey staff toured the facility with construction consultant (CC)-R. At the time of the survey, the kitchen, dining and activities rooms was under various forms of construction. CC-R stated that they had to renovate these rooms due to some water	0 830		

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0 830	Continued From page 29 damage and a newly added on daycare added to the facility. CC-R was not able to provide a floorplan at the time of survey, so the extent of construction/ renovation was not able to be determined. Building permits and approvals and MDH approvals for renovation were not able to be provided. Facilities undergoing construction and renovation must get proper approvals from MDH and MN DLI or local building authority prior to starting construction or renovation. CC-R stated he understood no residents could occupy the house and stated there were no plans to move anyone into that space until it was finished. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 830		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the	0 970		

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0 970	Continued From page 30 facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee's undated Assisted Living with Dementia Care Service Contract (assisted living contract), included the following clause that a resident would waive the facility's liability for health, safety, or personal property of the resident: -Page 11: number 19: Resident may park their personal vehicle in the parking lot adjacent to the facility. Facility assumes no responsibility for the security or safety of the vehicles or for the personal property kept in the vehicles. On July 15, 2025, at 9:50 a.m., administrative assistant (AA)-A stated to AA-A's knowledge the same contract was used for all residents. AA-A further stated the licensee was not responsible for resident's personal property in a resident's vehicle on the licensee's premises, and AA-A was not aware a waiver of liability could not be in the assisted living contract. On July 16, 2025, at 12:50 p.m., clinical nurse supervisor (CNS)-B stated administrator(A)-N was responsible for resident contracts and	0 970		

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0 970	Continued From page 31 CNS-B was not aware the assisted living contract listed a waiver of liability. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current employee records contained all the required content to include a current background study clearance letter for three of 13 employees (unlicensed personnel (ULP)-I, ULP-L, dietary aide (DA)-K). In addition, the licensee failed to ensure the employee's current background study clearance was affiliated with the correct health	01290		

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01290	Continued From page 32 care facility identification (HFID) for two of 10 employees (ULP-J, ULP-M) This had the potential to affect all residents living within the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: This resulted in an immediate correction order on July 16, 2025. During the entrance conference on July 14, 2025, at 11:32 a.m., consultant (C)-C stated C-C was aware of required contents in an employee record. NO BACKGROUND STUDY ULP-I ULP-I was hired on March 12, 2022, to provide direct care services to residents at the facility. On July 14, 2025, at 2:53 p.m., the surveyor observed ULP-I working independently at the medication cart. ULP-I stated ULP-I worked full time for the licensee. The licensee's weekly schedule dated June 22, 2025, through July 19, 2025, indicated ULP-I was scheduled to work 20 out of 84 scheduled shifts.	01290		

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01290	Continued From page 33 ULP-I's Direct Deposit dated July 11, 2025, indicated ULP-I had worked 106.11 hours from June 22, 2025, through July 5, 2025. ULP-L ULP-L was hired on August 30, 2024, to provide direct care services to residents at the facility. A paystub was requested for ULP-L, however, was not provided. DA-K DA-K was hired on an unknown date to assist with providing dining services to residents at the facility. DA-K's Direct Deposit dated July 11, 2025, indicated DA-K had worked 4.90 hours from June 22, 2025, through July 5, 2025. ULP-I, ULP-L, and DA-K's employee records lacked a current cleared background study. WRONG AFFILIATION ULP-J ULP-J was hired on March 12, 2022, to provide direct care services to residents at the facility. On July 14, 2025, at 2:52 p.m., the surveyor observed ULP-J working independently at the facility. ULP-J stated ULP-J worked full time for the licensee and usually worked the overnight shift. The licensee's Labor Distribution dated December 22, 2024, through March 15, 2025, indicated ULP-J had worked 39.17 hours for the licensee.	01290		

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01290	Continued From page 34 ULP-M ULP-M was hired on October 4, 2024, to provide direct care services to residents at the facility. A paystub was requested for ULP-M, however, was not provided. ULP-J and ULP-M's employee records contained a background study with the HFID of a sister facility location and not the correct HFID for the licensee. On July 15, 2025, from 10:28 a.m. through 10:30 a.m., the surveyor reviewed the licensee's NETStudy 2.0 roster with administrative assistant (AA)-A. AA-A stated ULP-I, ULP-L, DA-K, ULP-J, and ULP-M were current employees for the licensee with out direct supervision. On July 15, 2025, at 11:42 a.m., C-C stated administrator (A)-N was responsible for completion of employee background studies. C-C further stated no employee should be working on the floor with residents without a current cleared background study. On July 15, 2025, 1:09 p.m., C-C stated C-C searched the NETStudy 2.0 website for ULP-I, ULP-L, and DA-K names, however, the no results were found. The licensee's Background Study policy dated October 2010, indicated documentation of eligibility will be obtained from the Department of Human Services and will be placed in the employee's personnel record. Continuous Direct Supervision defined in NETStudy 2.0 System User Manual Updated July	01290		

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01290	Continued From page 35 7, 2023, page 7: Continuous, Direct Supervision - An individual is within sight or hearing of the program's supervising individual to the extent that the program's supervising individual is capable at all times of intervening to protect the health and safety of the persons served by the program. Direct Contact Services - Providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the entity. Supervision defined in, NETStudy 2.0 System User Manual Updated July 7, 2023, page 53: Supervision Status Study subjects must be under continuous, direct supervision until the study subject is determined eligible of until the entity is notified by DHS that the study subject may provide unsupervised services while the background study is being completed. The supervision status is shown in the "Supervision Required" column for convenience. However, programs are instructed to rely on background study notices for supervision status and other background study determination information. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors (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	01460		

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VALLEY ASSISTED LIVING	523 ARNOLD AVENUE SOUTH THIEF RIVER FALLS, MN 56701

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01460	Continued From page 36 completed once for each staff person and is not transferable to another facility, except as provided in paragraph (b). (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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide staff orientation to assisted living licensing requirements and regulations for one of four employees (dietary aide (DA)-P). This had the potential to affect all 15 residents. This practice resulted in a level two violation (a violation that has no potential to cause more than	01460		

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	30224	A. BUILDING: _____ B. WING _____	07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY ASSISTED LIVING	523 ARNOLD AVENUE SOUTH THIEF RIVER FALLS, MN 56701

(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
01460	Continued From page 37 a minimal impact on the resident and does not affect health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on July 14, 2025, at 11:32 a.m., consultant (C)-C stated C-C was aware of required contents in an employee record. DA-P was hired on July 3, 2019, to assist with providing dining services to residents at the facility on August 1, 2021. DA-P's employee record indicated DA-P completed Home Care Orientation on June 11, 2019. DA-P's employee record lacked documentation to indicate DA-P completed orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. On July 16, 2025, at 9:34 a.m., C-C stated C-C had provided the surveyor with all the licensee's documentation C-C was able to locate. On July 16, 2025, at 1:30 p.m., clinical nurse supervisor (CNS)-B stated all staff were assigned to complete the same training via Educare (online training platform), however, if the education was not completed it would not be listed on the employee's Educare transcript.	01460		

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01460	Continued From page 38 The licensee's Orientation and Annual Training Requirements-Including Dementia Training policy dated March 2022, indicated all staff providing and supervising direct services must complete an orientation to assist living facility licensing requirements and regulations before providing assisted living services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460		
01500 SS=F	144G.63 Subd. 5 Required annual training (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: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (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; (4) effective approaches to use to problem solve when working with a resident's challenging	01500		

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01500	Continued From page 39 behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (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 (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. 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: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an employee received all the required content for annual training for each 12 months of employment for one of one employee (registered nurse (RN)-D).	01500		

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01500	Continued From page 40 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 14, 2025, at 11:32 a.m., consultant (C)-C stated C-C was aware of required contents in an employee record. RN-D was hired on August 21, 2018, and provided direct care and RN on call services for supervision to residents and staff at the assisted living effective August 1, 2021. RN-D's employee record lacked documentation of review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures as part of annual training provided by the licensee. On July 16, 2025, at 9:34 a.m., C-C stated C-C had provided the surveyor with all the licensee's documentation C-C was able to locate. On July 16, 2025, at 1:08 p.m., clinical nurse supervisor (CNS)-B stated the licensee was "probably" behind on annual training with all required topics to cover for all staff. The licensee's Orientation and Annual Training	01500		

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01500	Continued From page 41 Requirements-Including Dementia Training policy dated March 2022, indicated content of required annual training included review of facility's policies and procedures related to assisted living provision of assisted living services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01540 SS=F	144G.64 (a) (3) Training in Dementia, Mental Illness, and De- (3) for assisted living facilities with dementia care, direct-care staff must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, the 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 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; This MN Requirement is not met as evidenced	01540		

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01540	Continued From page 42 by: Based on observation, interview, and record review, the licensee failed to ensure two of two employees (registered nurse (RN)-D, unlicensed personnel (ULP)-H) received the required amount of mental illness and de-escalation training within the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility with dementia care (ALFDC) license issued on November 1, 2024, through October 31, 2025. During the entrance conference on July 14, 2025, at 11:32 a.m., consultant (C)-C stated C-C was aware of required contents in an employee record. RN-D RN-D was hired on August 21, 2018, and provided direct care and RN on call services for supervision to residents and staff at the assisted living effective August 1, 2021. The licensee's Labor Distribution dated December 22, 2024, through March 15, 2025, indicated RN-D had worked over 1,340 hours for the licensee.	01540		

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01540	Continued From page 43 RN-D's employee record lacked RN-D had completed any training mental illness or de-escalation by July 1, 2025. ULP-H ULP-H was hired on April 30, 2025, to provide direct care services to residents at the facility. On July 15, 2025, at 3:57 p.m., the surveyor observed ULP-H provide scheduled afternoon medication administration for R6. The licensee's Weekly schedule dated June 22, 2025, through July 12, 2025, indicated ULP-H had worked 126 hours for the licensee. ULP-H's employee transcript indicated ULP-H completed one (1) hour of Mental Illness-Response Strategies on May 20, 2025. ULP-H's employee record lacked ULP-H had completed two (2) hours of mental illness and de-escalation training by July 1, 2025. On July 16, 2025, at 1:13 p.m., clinical nurse supervisor (CNS)-B stated mental illness, de-escalation, and annual dementia training were supposed to be assigned to each employee on Educare (online training platform), however, CNS-B stated CNS-B was not sure if the topics were assigned to each employee. On July 16, 2025, at 1:30 p.m. CNS-B stated all employees were "due" to complete mental illness, de-escalation, and dementia trainings. On July 16, 2025, at 9:34 a.m., C-C stated C-C had provided the surveyor with all the licensee's documentation C-C was able to locate.	01540		

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01540	Continued From page 44 On July 17, 2025, at 8:14 p.m., C-C emailed (electronic mail) C-C was unable to locate a policy for mental illness and de-escalation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01550 SS=F	144G.64 (a) (4) Training in Dementia, Mental Illness, and De- (4) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on 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, and 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; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure three of three employees (housekeeper (HSKP)-E, dietary aide (DA)-P, DA-K) received the required amount of mental illness and de-escalation in the required time frame. In addition, the licensee failed to ensure two of two employees (HSKP-E, DA-P) received annual dementia training for each	01550		

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01550	Continued From page 45 12 months of employment after hire. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 14, 2025, at 11:32 a.m., consultant (C)-C stated C-C was aware of required contents in an employee record. HSKP-E HSKP-E was hired on June 22, 2023, to provide housekeeping to residents at the facility. Throughout the survey on July 14, 2025, through July 16, 2025, the surveyor observed HSKP-E cleaning the facility and resident apartments. DA-P DA-P was hired on July 3, 2019, to assist with providing dining services to residents at the facility on August 1, 2021. DA-K DA-K was hired on an unknown date to assist with providing dining services to residents at the facility. HSKP-E, DA-P, and DA-K's employee records lacked two hours of initial training on mental illness and de-escalation.	01550		

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01550	Continued From page 46 In addition, HSKP-E and DA-P's employee records lacked two hours of annual dementia training for each 12 months of employment. On July 16, 2025, at 9:34 a.m., C-C stated C-C had provided the surveyor with all the licensee's documentation C-C was able to locate. On July 16, 2025, at 1:13 p.m., clinical nurse supervisor (CNS)-B stated mental illness, de-escalation, and annual dementia training were supposed to be assigned to each employee on Educare (online training platform), however, CNS-B stated CNS-B was not sure if the topics were assigned to each employee. On July 16, 2025, at 1:30 p.m. CNS-B stated all employees were "due" to complete mental illness, de-escalation, and dementia trainings. The licensee's Orientation and Annual Training Requirements-Including Dementia Training policy dated March 2022, indicated staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least 2 (two) hours of training on topics related to dementia care for each 12 months of employment thereafter. The policy did not address training on mental illness or de-escalation. On July 17, 2025, at 8:14 p.m., C-C emailed (electronic mail) C-C was unable to locate a policy for mental illness and de-escalation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01550		

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01550	Continued From page 47 (21) days	01550		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall	01620		

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01620	Continued From page 48 complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the registered nurse (RN) failed to conduct a comprehensive reassessment for one of two residents (R4). This practice resulted in a level two violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on July 14, 2025, at 1:08 p.m., clinical nurse supervisor (CNS)-B stated CNS-B completed a preadmission, 14-day, 90-day, and change of condition assessments on residents when CNS-B was	01620		

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01620	Continued From page 49 onsite at the facility during the day. R4's diagnoses included diabetes, hypertension (HTN- high blood pressure), and depression. R4's Service Plan (Waiver)- Addendum to Contract dated May 20, 2025, indicated R4's services included medication administration, blood glucose checks, assistance with bathing grooming, dressing, and light housekeeping. On July 15, 2025, at 11:00 a.m., the surveyor observed unlicensed personnel (ULP)-G administer scheduled morning medication for R4. R4's Resident Profile Notes included the following entries: -June 20, 2025, at 2:02 p.m., urine brought to clinic for suspected UTI (urinary tract infection)- positive results- order for antibiotic written by CNS-B; -June 25, 2025, at 7:33 a.m., R4 reported to ULP R4 does not eat all day long, R4 seems more depressed than usual written by ULP-F; -July 6, 2025, at 7:20 a.m., R4 was laying in bed, R4 asked for a knife to cut the cake that was sitting on R4's chest, also R4 said other bizarre things. R4 also said R4 went with R4's brother yesterday to visit the relatives at his house, however, ULP-F confirmed with staff that R4 never went over there written by ULP-F; -July 6, 2025, at 4:38 p.m., staff updated nurse this morning that R4 had slipped and fell out of R4's chair. No injuries no concerns. Vitals WNL (within normal limits). Family contacted per staff written by RN-D. -July 7, 2025, at 6:58 a.m., R4 wants to be fed in bed, doesn't want the ambulance called with continued weakness. When ULP-F helped R4 in	01620		

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(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
01620	Continued From page 50 the bathroom, R4 had to sit down several times before ULP-F could finish wiping R4 written by ULP-F; -July 7, 2025, at 7:39 a.m., staff called this am (morning) to report resident was co [sic] and off. R4 refused to go to ER. R4 has an appointment today written by RN-D; -July 7, 2025, at 9:51 a.m., noted recent diagnosis of UTI with antibiotics- and noted confusion written by CNS-B; and -July 12, 2025, at 6:21 a.m., R4 stated R4 was at (person's name) house yesterday, which R4 wasn't there. Also, R4 had a chicken salad sandwich rolled up in R4's blanket, ULP-F unrolled R4's blanket to show R4 that nothing was there written by ULP-F. R4's Assessment dated May 20, 2025, indicated R4 had a history of UTI concerns, had generalized weakness and balance problem, had a history of major chronic depression, and oriented to person, place, and time of day. R4's record lacked a change of condition assessment after R4 was diagnosed with a UTI in June and July 2025, respectively, had a fall, R4 had begun to become more weak, depressed, and confused. On July 16, 2025, at 1:44 p.m., CNS-B stated falls, consumption of less food, new diagnosis, or feeling depressed would all trigger a change of condition assessment to be completed on a resident. CNS-B further stated CNS-B was not sure who documented the changes in R4 as CNS-B was not aware of the changes, however, CNS-B was going to complete a referral for R4's change in condition since the last assessment on May 20, 2025.	01620		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY ASSISTED LIVING	523 ARNOLD AVENUE SOUTH THIEF RIVER FALLS, MN 56701

(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
01620	Continued From page 51 The licensee's Service Plan policy dated March 30, 2021, indicated ongoing client monitoring and reassessment must be conducted as needed based on changes in the needs of the resident and cannot exceed 90-days from the last date of the assessment. The monitoring and reassessment may be conducted at the client's (resident's) residence or through the utilization of telecommunication methods based on practice standards that meet the individual client's (resident's) needs. Change in client (resident) conditions may include: pattern in increase/decrease in ADL (activities of daily living), patterns of increase/decrease in behaviors, and falls. The licensee's Assessment-Schedules policy dated June 3, 2015, indicated changes in client (resident) condition would be completed as indicted by an RN. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01710 SS=E	144G.71 Subd. 3 Individualized medication monitoring and reas A registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually.	01710		

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VALLEY ASSISTED LIVING	523 ARNOLD AVENUE SOUTH THIEF RIVER FALLS, MN 56701

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01710	Continued From page 52 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication management plan for each resident to include all required content for two of three residents (R2, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on July 14, 2025, at 10:50 a.m., consultant (C)-C stated the licensee provided medication management to residents at the facility. R2 R2's diagnoses included chronic obstructive pulmonary disease (COPD-difficult breathing), diabetes, and schizo-affective disorder. R2's Service Plan (Waiver)- Addendum to Contract dated September 25, 2024, indicated R2's services included medication administration five times per day. R2's prescriber orders dated September 12,	01710		

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01710	Continued From page 53 2024, included an order for budesonide 0.5 milligrams (mg)/ 2 milliliters (mL) inhale via nebulizer (a medical device that converts liquid medication into a fine mist) 0.5 mg/2 mL two times per day. On July 15, 2025, at 7:03 a.m., the surveyor observed unlicensed personnel (ULP)-G administer R2's scheduled morning medication. ULP-G poured R2's budesonide into R2's nebulizer chamber, handed R2 the nebulizer chamber, and turned on R2's nebulizer. ULP-G proceeded to leave R2's room and returned to the computer to document the administration of R2's medication. ULP-G stated R2 was able to independently complete the nebulizer administration and ULP-G would return to R2's room later to ensure R2 inhaled all the medication. R2's Individualized Medication Management Plan dated June 11, 2025, indicated med (medication) self-admin (administration) was not applicable and staff will administer all medications. R2's record lacked an updated Individualized Medication Management Plan for R2 to partially self-administer R2's budesonide. On July 16, 2025, at 1:38 p.m., clinical nurse supervisor (CNS)-B stated CNS-B should have updated R2's medication assessment as CNS-B had determined R2 could partially self-administer R2's budesonide via nebulizer. CNS-B stated medication assessments were typically updated every 90 days with the resident's assessment. R5 R5's diagnoses included schizoid personality	01710		

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01710	Continued From page 54 disorder, anxiety, and hypertension (HTN-high blood pressure). R5's Service Plan (Waiver)- Addendum to Contract dated September 19, 2024, indicated R5's services included medication administration two times per day. R5's prescriber orders dated September 4, 2024, included an order for timolol 0.25% ophthalmic solution instill one drop into both eyes two times per day. On July 15, 2025, at 7:07 a.m., the surveyor observed ULP-G hand R5 the timolol eye drops, R5 self-administered one drop into each eye, and R5 returned the timolol bottle back to ULP-G. ULP-G stated R5 was able to self-administer eye drops and insulin, however, the licensee stored all R5's medications. R5's Individualized Medication Management Plan dated May 27, 2025, indicated R5 assists with insulin admin (administration) after staff set up and guide. R5's record lacked an updated Individualized Medication Management Plan for R5 to self-administer R5's eye drops. On July 16, 2025, at 1:20 p.m., CNS-B stated ULPs were trained to follow the instructions listed on the resident's medication administration record (MAR). CNS-B further stated if the instructions did not list self-administration, then ULPs should have administered the eye drop. The licensee's Medication Management Services- Medication Aide policy dated June	01710		

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01710	Continued From page 55 2021, indicated a RN must conduct a face-to-face resident assessment to determine what medication management services that will be provided to the resident. In addition, a RN must ensure that specific instructions in writing, for each client (resident) and document those instructions in the resident centered plan of care. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered per prescriber orders for two of two residents (R2, R4) observed during medication administration.	01760		

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01760	Continued From page 56 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 14, 2025, at 10:50 a.m., consultant (C)-C stated the licensee provided medication management to residents at the facility. R2 R2's diagnoses included chronic obstructive pulmonary disease (COPD-difficult breathing), diabetes, and schizo-affective disorder. R2's Service Plan (Waiver)- Addendum to Contract dated September 25, 2024, indicated R2's services included medication administration five times per day. R2's prescriber orders dated September 12, 2024, included an order for levothyroxine (for thyroid) 100 micrograms (mcg)- take one table by mouth once daily before other medications. R2's Med (medication) Admin (administration) Summary dated, July 2025, indicated R2 received levothyroxine 100 mcg tablet by mouth once daily scheduled at 7:00 a.m., along with another medication scheduled at the same time. On July 15, 2025, at 7:03 a.m., the surveyor observed unlicensed personnel (ULP)-G	01760		

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01760	Continued From page 57 administer scheduled morning medication administration for R2. The surveyor observed ULP-G administer R2's levothyroxine 100 mcg tablet along with all medications scheduled for 7:00 a.m. and 8:00 a.m. The surveyor did not observe R2 receive levothyroxine 100 mcg tablet before all other scheduled medications. ULP-G stated ULP-G had one hour before or after scheduled medication times to administered medications, which indicated all 7:00 a.m. and 8:00 a.m., medications were able to be administered together. The manufacturer instructions for levothyroxine dated August 2022, indicated to administer levothyroxine on an empty stomach, one-half to one hour before breakfast. R4 R4's diagnoses included diabetes, hypertension (HTN- high blood pressure), and depression. R4's Service Plan (Waiver)- Addendum to Contract dated May 20, 2025, indicated R4's services included medication administration nine times per day. R4's prescriber orders dated November 24, 2024, included an order for Rybelsus (for diabetes) 3 mg tablet- take one tablet by mouth once daily on an am empty stomach 30 minutes before first food, beverage, or other medication with four ounces or less of plain water only. R4's Med (medication) Admin (administration) Summary dated July 2025, indicated R4 received Rybelsus 3 mg tablet by mouth once daily on an empty stomach 30 minutes before first food, beverage, or other medication with four ounces	01760		

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01760	Continued From page 58 or less of plain water only scheduled at 11:30 a.m. R4's Med Admin Summary further indicated R4 was administered eight scheduled medications daily at 8:00 a.m. On July 16, 2025, at 1:35 p.m., clinical nurse supervisor (CNS)-B stated some levothyroxine instructions indicated to take an hour before other medications or food on an empty stomach and some levothyroxine instructions do not indicate to take an hour prior to other medications or food. CNS-B further stated ULPs were trained to follow the instructions on the resident's electronic medication administration records (EMAR). The licensee's Medication Reminders, Medication Set ups [sic] policy dated August 26, 2020, indicated the med aide (ULP) or nurse will use the MAR for documenting medications given from a dosage box and will refer to the medications profile listing the medication name, strength, description, amount to be given, and time of day to be given, as well as the purpose of the medication and any special instructions if applicable. The licensee's Medication and Treatment Orders Implementation policy dated August 26, 2020, indicated orders received will be implemented when in direct contact with the nurse. The policy further indicated, changes will be made to the MAR, by a nurse, if indicated. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

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01770	Continued From page 59	01770		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on July 14, 2025, at 10:50 a.m., consultant (C)-C stated the licensee provided medication management to residents at the facility. R3's diagnoses included hypertension (HTN-high blood pressure), depression, and anxiety. R3's Service Plan (Waiver)- Addendum to Contract (service plan) dated August 6, 2024, indicated R3 received medication set up/storage one time per week.	01770		

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01770	Continued From page 60 R3's prescriber orders dated August 21, 2024, included the following orders: -cerovite senior (supplement)- one tablet by mouth daily; -citalopram (for depression/anxiety) 10 milligrams (mg)- one tablet by mouth daily; -Eliquis (for deep vein thrombosis-DVT) 5 mg- take one tablet by mouth twice daily; -losartan (for HTN) 50 mg- take one tablet by mouth daily; -magnesium oxide (supplement) 400 mg- one tablet by mouth daily; -Mybetriq (for bladder) 25 mg- one tablet by mouth daily; -potassium (supplement) 10 milliequivalent (mEq)- one tablet by mouth daily; and -torsemide (for leg swelling) 20 mg- one tablet by mouth daily. On July 15, 2025, at 6:37 a.m., the surveyor reviewed the "Lane 2" medication cart with unlicensed personnel (ULP)-F. ULP-F stated the medication planner (a weekly box with separate compartments to place medications to be administered at certain times of the day) was set up by clinical nurse supervisor (CNS)-B every week for R3. ULP-F further stated R3 was able to self-administer medications after CNS-B setup the medication planner. R3's Individualized Medication Management Plan dated May 14, 2025, indicated Nurse sets up medication box (planner) and R5 self-administered from the med (medication) box (planner). R3's Med (medication) Setup/ Review Summary-Month dated July 2025, was blank.	01770		

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01770	Continued From page 61 R3's record lacked documentation for medication setup at the time of setup to include the dates of medication setup, name of the medication, quantity of dose, times to be administered, route of administration and name of person completing medication setup at the time of setup. On July 16, 2025, at 1:17 p.m., CNS-B stated CNS-B was not instructed correctly on how to document a medication set up. CNS-B further stated CNS-B documented on a nurse note of R3's medication setup, however, CNS-B stated the documentation did not meet the medication setup documentation requirement. CNS-B stated CNS-B was recently informed of the medication setup requirements. The licensee's Medication Reminders, Medication Set ups policy dated August 26, 2020, indicated a licensed nurse will set up medications in dosage boxes (medication planner) for the client (resident), usually on a weekly basis, and will make or direct changes between set ups when necessary. The policy did not address documentation of the medication set up. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for	01790		

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01790	Continued From page 62 the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident,	01790		

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01790	Continued From page 63 and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) developed written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. In addition, the licensee failed to ensure one of one ULP (ULP-H) was trained and had demonstrated competency to prepare and give medications for residents having unplanned time away. 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).	01790		

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VALLEY ASSISTED LIVING	523 ARNOLD AVENUE SOUTH THIEF RIVER FALLS, MN 56701

(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
01790	Continued From page 64 The findings include: During the entrance conference on July 14, 2025, at 10:50 a.m., consultant (C)-C stated the licensee provided medication management to residents at the facility. UNPLANNED TIME AWAY POLICY AND PROCEDURE FOR ULP The licensee's Medication Administration-Outings policy dated August 26, 2020, indicated for unplanned resident time away the RN may delegate this task to the ULP for unplanned time away not to exceed five days (120 hours). The policy indicated any medications not taken will be documented in the client's (resident's) record by the nurse that received the form and medications. The licensee's policy lacked written procedures the RN developed to include the following: -the RN has trained the ULP and determined the ULP is competent to follow the procedures for giving medications to residents; -the RN has developed written procedures for the ULP, including any special instructions or procedures regarding controlled substances that are prescribed for the resident; -written information about the medications to be provided; -the type of container to be used for the medications appropriate to the facility's medication system; and -how the ULP must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each medication returned.	01790		

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	30224	A. BUILDING: _____ B. WING _____	07/16/2025

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VALLEY ASSISTED LIVING	523 ARNOLD AVENUE SOUTH THIEF RIVER FALLS, MN 56701

(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
01790	Continued From page 65 TRAINING AND COMPETENCY EVALUATIONS ULP-H was hired on April 30, 2025, to provide direct care services to residents at the assisted living with dementia care facility. On July 15, 2025, at 3:57 p.m., the surveyor observed ULP-H provide scheduled afternoon medication administration for R6. ULP-H's employee record lacked evidence to indicate ULP-H had been trained and had demonstrated competency to provide medications to residents for unplanned time away from the facility. On July 16, 2025, at 1:25 p.m., clinical nurse supervisor (CNS)-B stated CNS-B unplanned time away training and competency was completed with the initial medication administration training and was based on the facility's policy. The surveyor reviewed the Medication Administration- Outings policy dated August 26, 2020, with CNS-B. CNS-B stated the policy was supposed to indicate for ULPs to use envelopes with resident information listed on the outside, how to take each medication, and if the resident returned with medications not taken, the ULP would have returned the medications to CNS-B for destruction. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically	01820		

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01820	Continued From page 66 recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for two of two residents (R2, R4) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on July 14, 2025, at 10:50 a.m., consultant (C)-C stated the licensee provided medication management to residents at the facility. R2 R2's diagnoses included chronic obstructive pulmonary disease (COPD-difficult breathing), diabetes, and schizo-affective disorder. R2's Service Plan (Waiver)- Addendum to Contract dated September 25, 2024, indicated R2's services included medication administration five times per day.	01820		

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01820	Continued From page 67 On July 15, 2025, at 7:03 a.m., the surveyor observed unlicensed personnel (ULP)-G administer scheduled morning medication administration for R2. R2's prescriber orders dated September 12, 2024, included the following medication: -vitamin D3 (supplement) 25 micrograms (mcg) by mouth daily -Miralax Powder (for constipation) 17 grams (g) by mouth every morning mixed with 8 ounces of water or liquid of choice -Seroquel (for schizophrenia) 200 milligrams (mg) by mouth every night R2's Med (medication) Admin (administration) Summary- Actual- Month dated July 2025, indicated R2's medication administration included the following medications: -Alendronate (for bone health) 35 mg was administered for a scheduled 6:00 a.m., medication on July 1, and 8, respectively; -Cholestyramine powder (for high cholesterol) 4 g was administered for a scheduled 8:00 a.m., medication on July 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, and 14, respectively; -nicotine (for smoking cessation) 21 mg/24-hour patch was offered to be administered for a scheduled 8:00 a.m., medication on July 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, and 14, respectively and was administered on July 13; -Asenapine (antipsychotic) 5 mg was administered for a scheduled 8:00 p.m., medication on July 1, 2, 3, 5, and 9, respectively, and was offered to be administered on July 4, 6, 7, 8, 10, 11, 12, and 13, respectively; and -Vraylar (antipsychotic) 3 mg was administered for a scheduled 9:00 p.m., medication on July 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, and 13,	01820		

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01820	Continued From page 68 respectively. R2's record lacked prescriber orders for the above noted medications. In addition, R2's record lacked prescriber orders to discontinue vitamin D3, Miralax powder, and Seroquel. On July 16, 2025, at 1:31 p.m., clinical nurse supervisor (CNS)-B stated CNS-B received separate orders for resident's medications if there was a change different than annual orders signed. CNS-B further stated CNS-B had "5,000 papers" to scan into resident records and would provide R2's orders noted above, however, the surveyor received no additional orders for R2. R4 R4's diagnoses included diabetes, hypertension (HTN- high blood pressure), and depression. R4's Service Plan (Waiver)- Addendum to Contract dated May 20, 2025, indicated R4's services included medication administration nine times per day. On July 15, 2025, at 11:00 a.m., the surveyor observed ULP-G administer scheduled morning medication administration for R4. R4's prescriber orders dated November 24, 2024, included the following medications: -Duloxetine (for depression) 30 mg by mouth daily -Lantus Solostar (insulin) 100 units per milliliter (mL) inject 28 units under the skin one time per day R4 Med (medication) Admin (administration) Summary- Actual- Month dated July 2025,	01820		

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01820	Continued From page 69 indicated R4's medication administration included the following medications: -Duloxetine 60 mg was administered as a scheduled medication at 8:00 a.m., on July 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, and 14, respectively; -Lantus Solostar 20 units were administered as a scheduled medication at 12:00 p.m., on July 1, 2, 3, 4, 5, 6, and 7, respectively; and -Lantus Solostar 10 units were administered as a scheduled medication at 12:00 p.m., on July 8, 9, 10, 11, 12, and 13, respectively. R4's record lacked prescriber orders to increase Duloxetine to 60 mg and decrease Lantus Solostar to 10 units per day. On July 16, 2025, at 1:45 p.m., CNS-B stated CNS-B had additional orders to provide for R4, however, the orders received from CNS-B lacked the above noted medications. The licensee's Medication and Treatment Orders policy dated August 26, 2020, indicated the RN (registered nurse) is responsible for assuring that current, authorized prescriber orders for medication or treatments administered by the staff are kept on file in the client's (resident's) medical chart. In addition, all orders for medications and treatments must be complete, dated and signed by the prescriber and must be current and consistent with the nursing assessment [sic]. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		

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01880	Continued From page 70	01880		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were stored according to manufacturer's instructions for one of one medication refrigerator. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on July 14, 2025, at 10:50 a.m., consultant (C)-C stated the licensee provided medication management to residents at the facility. On July 16, 2025, at 10:21 a.m., the surveyor reviewed the medication refrigerator locked in the unlicensed personnel (ULP)/nurse office. ULP-H stated the current temperature of the refrigerator was 30 degrees Fahrenheit (F), and ULPs checked the refrigerator temperature one time per day. The refrigerator included the following	01880		

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01880	Continued From page 71 medications: -two unopened Ozempic 4 milligrams (mg)/3 milliliters (mL) injections for R6 -14 unopened Lantus 100 units/mL insulin pens for R6 -15 unopened Toujeo Solostar 300 units/mL insulin pens for R5 The licensee's Chore History dated June 1, 2025, through July 16, 2025, indicated if the temperature was outside of the ranges of 36-46 degrees F, ensure that the fridge was properly closing and recheck the temperature within 30 minutes. Record the new temperature by selecting an "unscheduled chose" and recording was accordingly [sic]. If still outside of the range of 36-46 degrees F, contact administration, nursing, and maintenance through a notice in Rtasks (online documentation platform) messaging as well as call maintenance to address the concern. In the "unscheduled chore" note that you have sent a Rtask message and contacted maintenance. The following documentation was logged on the Chore History for the medication refrigerator being checked twice daily: -20 out of 92 opportunities the refrigerator temperature was documented as completed with no record of the refrigerator temperature -42 out of 72 opportunities the refrigerator temperature was documented as "okay", "k", "kk", "ok", or "done" -one (1) out of 30 opportunities the refrigerator temperature documented was not in range of 36-46 degrees F -On July 16, 2025, at 9:47 a.m., ULP-H documented the refrigerator temperature was "okay" (the refrigerator temperature was 30 degrees F at 10:21 a.m.)	01880		

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01880	Continued From page 72 On July 16, 2025, at 1:26 p.m., clinical nurse supervisor (CNS)-B stated the medication refrigerator temperature range was supposed to be kept between 36 to 46 degrees F. CNS-B further stated ULPs were supposed to contact the nurse on call if the refrigerator was out of temperature range, follow instructions from the nurse on call, and recheck the medication refrigerator temperature later for appropriate temperature range. The manufacturer's instructions for Ozempic dated October 2022, indicated before opening store the Ozempic pens in the refrigerator (36-46 degrees F). Do not allow the Ozempic to freeze. The manufacturer's instructions for Lantus insulin pens dated November 2018, indicated before opening store the insulin pens in the refrigerator (36-46 degrees F). Do not allow the Lantus to freeze. The manufacturer's instructions for Toujeo insulin pens dated February 2015, indicated before opening store the insulin pens in the refrigerator (36-46 degrees F). Do not allow the Toujeo to freeze. The licensee's Storage of Medications policy dated February 2022, indicated medications shall be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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01930 SS=F	144G.72 Subd. 2 Policies and procedures (a) An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines. (b) The written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting treatment or therapy activities, educating and communicating with residents about treatments or therapies they are receiving, monitoring and evaluating the treatment or therapy, and communicating with the prescriber. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures that were developed under the supervision and direction of a registered nurse (RN) consistent with current practice standards and guidelines. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	01930		

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01930	Continued From page 74 The findings include: During the entrance conference on July 14, 2025, at 11:00 a.m., consultant (C)-C stated the licensee provided treatment and therapy services to residents at the facility. On July 15, 2025, at 6:53 a.m., the surveyor observed unlicensed personnel (ULP)-G complete a blood glucose check for R4. The treatment and therapy policies provided did not include policies to address the following: -providing the treatment or therapy; -documenting the treatment or therapy; -monitoring and evaluating the treatment or therapy; and -communicating with the prescriber. On July 16, 2025, at 9:34 a.m., C-C stated C-C had provided the surveyor with all the licensee's documentation C-C was able to locate. On July 17, 2025, at 8:14 p.m., C-C emailed (electronic mail) C-C had provided all policies the surveyor requested, however, no additional treatment or therapy policies were provided to the surveyor. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01930		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of	01940		

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01940	Continued From page 75 ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of two residents (R2) who had treatments or therapies managed by the licensee.	01940		

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01940	Continued From page 76 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on July 15, 2025, at 11:00 a.m., consultant (C)-C stated the licensee provided treatment and therapy services to residents at the facility. R2's diagnoses included chronic obstructive pulmonary disease (COPD-difficult breathing), diabetes, and schizo-affective disorder. R2's Service Plan (Waiver)- Addendum to Contract dated September 25, 2024, indicated R2's services included oxygen management three times per day, and record oxygen saturation (level of oxygen in the blood) one time per month. R2's prescriber orders dated September 12, 2024, indicated oxygen management three times daily. R2's Assessment dated June 11, 2025, indicated R2 wore oxygen 2 liters (L) via nasal cannula (a flexible tube with two prongs, which delivers oxygen through the nose) at all times (continuously). On July 15, 2025, at 7:03 a.m., the surveyor observed unlicensed personnel (ULP)-G	01940		

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01940	Continued From page 77 administer scheduled morning medication administration for R2 and observed an oxygen concentrator located in R2's room, however, the oxygen concentrator was not in use. ULP-G stated R2 wore oxygen as needed. R2's record lacked a treatment plan including the following required information: -written statement of the treatment or therapy (oxygen) that would be provided; -documentation of specific resident instructions relating to the oxygen; -identification of treatment or therapy task that would be delegated to ULPs; -procedures for notifying a registered nurse (RN) when a problem arose with the oxygen; and -and resident-specific requirements relating to documentation of treatment or therapy received, verification that all treatment or therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On July 16, 2025, at 1:39 p.m., clinical nurse supervisor (CNS)-B stated R2's oxygen was not entered correctly as a treatment in R2's electronic medical record and CNS-B would have to double check on R2's oxygen treatment. CNS-B further stated each treatment for a resident required an individualized treatment management plan. A policy was requested, however, was not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

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VALLEY ASSISTED LIVING	523 ARNOLD AVENUE SOUTH THIEF RIVER FALLS, MN 56701

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01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions for one of two residents (R2) receiving treatment management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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).	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30224	A. BUILDING: _____ B. WING _____	07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY ASSISTED LIVING	523 ARNOLD AVENUE SOUTH THIEF RIVER FALLS, MN 56701

(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
01950	Continued From page 79 The findings include: During the entrance conference on July 15, 2025, at 11:00 a.m., consultant (C)-C stated the licensee provided treatment and therapy services to residents at the facility. R2's diagnoses included chronic obstructive pulmonary disease (COPD-difficult breathing), diabetes, and schizo-affective disorder. R2's Service Plan (Waiver)- Addendum to Contract dated September 25, 2024, indicated R2's services included oxygen management three times per day, and record oxygen saturation (level of oxygen in the blood) one time per month. R2's prescriber orders dated September 12, 2024, indicated oxygen management three times daily. R2's Assessment dated June 11, 2025, indicated R2 wore oxygen 2 liters (L) via nasal cannula (a flexible tube with two prongs, which delivers oxygen through the nose) at all times (continuously). On July 15, 2025, at 7:03 a.m., the surveyor observed unlicensed personnel (ULP)-G administer scheduled morning medication administration for R2 and observed an oxygen concentrator located in R2's room, however, the oxygen concentrator was not in use. ULP-G stated R2 wore oxygen as needed. R2's Service Recap Summary- Actual- Month dated June 2025, and July 2025, respectively indicated oxygen management was documented	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01950	Continued From page 80 AM (morning), PM (afternoon), and overnight. R2's Treatment Recap Summary- Monthly dated July 2025, was blank and no treatments were listed. R2's record lacked specific instructions for when ULPs should notify the RN when a problem arises regarding oxygen management and communicated with the ULP about the individual needs of R2. On July 16, 2025, at 1:39 p.m., clinical nurse supervisor (CNS)-B stated R2's oxygen was not entered correctly as a treatment in R2's electronic medical record and CNS-B would have to double check on R2's oxygen treatment. CNS-B further stated documentation of oxygen management did not provide any instructions or details regarding R2's oxygen and was just a service ULPs signed off on three times per day. A policy was requested, however, was not provided. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01950		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration.	01960		

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VALLEY ASSISTED LIVING	523 ARNOLD AVENUE SOUTH THIEF RIVER FALLS, MN 56701

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01960	Continued From page 81 When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment services were documented as administered as prescribed, or to document the reason they were not provided for one of two residents (R2) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on July 15, 2025, at 11:00 a.m., consultant (C)-C stated the licensee provided treatment and therapy services to residents at the facility. R2's diagnoses included chronic obstructive pulmonary disease (COPD-difficult breathing), diabetes, and schizo-affective disorder. R2's Service Plan (Waiver)- Addendum to Contract dated September 25, 2024, indicated R2's services included oxygen management three times per day, and record oxygen	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01960	Continued From page 82 saturation (level of oxygen in the blood) one time per month. R2's prescriber orders dated September 12, 2024, indicated oxygen management three times daily. R2's Assessment dated June 11, 2025, indicated R2 wore oxygen 2 liters (L) via nasal cannula (a flexible tube with two prongs, which delivers oxygen through the nose) at all times (continuously). On July 15, 2025, at 7:03 a.m., the surveyor observed unlicensed personnel (ULP)-G administer scheduled morning medication administration for R2 and observed an oxygen concentrator located in R2's room, however, the oxygen concentrator was not in use. ULP-G stated R2 wore oxygen as needed. R2's Service Recap Summary- Actual- Month dated June 2025, and July 2025, respectively indicated oxygen management was documented AM (morning), PM (afternoon), and overnight. R2's Treatment Recap Summary- Monthly dated July 2025, was blank and no treatments were listed. R2's record lacked documentation of oxygen being applied, removed, oxygen flow rate, or route administered. On July 16, 2025, at 1:39 p.m., clinical nurse supervisor (CNS)-B stated R2's oxygen was not entered correctly as a treatment in R2's electronic medical record and CNS-B would have to double check on R2's oxygen treatment.	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01960	Continued From page 83 CNS-B further stated documentation of oxygen management did not provide any instructions or details regarding R2's oxygen and was just a service ULPs signed off on three times per day. A policy was requested, however, was not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of two residents (R2) who received treatments managed by the provider. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number	01970		

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01970	Continued From page 84 of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on July 15, 2025, at 11:00 a.m., consultant (C)-C stated the licensee provided treatment and therapy services to residents at the facility. R2's diagnoses included chronic obstructive pulmonary disease (COPD-difficult breathing), diabetes, and schizo-affective disorder. R2's Service Plan (Waiver)- Addendum to Contract dated September 25, 2024, indicated R2's services included oxygen management three times per day, and record oxygen saturation (level of oxygen in the blood) one time per month. R2's Assessment dated June 11, 2025, indicated R2 wore oxygen 2 liters (L) via nasal cannula (a flexible tube with two prongs, which delivers oxygen through the nose) at all times (continuously). R2's Service Recap Summary- Actual- Month dated June 2025, and July 2025, respectively indicated oxygen management was documented AM (morning), PM (afternoon), and overnight. R2's Treatment Recap Summary- Monthly dated July 2025, was blank and no treatments were listed. On July 15, 2025, at 7:03 a.m., the surveyor observed unlicensed personnel (ULP)-G administer scheduled morning medication	01970		

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01970	Continued From page 85 administration for R2 and observed an oxygen concentrator located in R2's room, however, the oxygen concentrator was not in use. ULP-G stated R2 wore oxygen as needed. R2's prescriber orders dated September 12, 2024, indicated oxygen management three times daily. R2's record lacked a prescriber order for oxygen to include the frequency, duration, and other information needed to administer the oxygen. On July 16, 2025, at 1:40 p.m., clinical nurse supervisor (CNS)-B stated R2's record lacked a specific oxygen order. CNS-B further stated CNS-B was aware treatments required a signed prescriber order. The licensee's Medication and Treatment Orders policy dated August 26, 2020, indicated a RN (registered nurse), LPN (licensed practical nurse), therapist or person qualified to receive orders will obtain all medications and treatment orders either in writing, verbally, or electronically by an authorized prescriber per the Comprehensive home care regulations [sic]. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care must meet the requirements of section 144G.45 and the following additional requirements:	02040		

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02040	Continued From page 86 (1) an assessment of safety risks must be performed on and around the property. The safety risks identified by the facility on the assessment must be mitigated to protect the residents from harm. The mitigation efforts must be documented in the facility's records; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on July 15, 2025, at 2:45 p.m. with consultant (C) -C on the hazard vulnerability assessment for the physical environment of the facility. Record review indicated that the licensee had not performed a hazard vulnerability assessment	02040		

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02040	Continued From page 87 with risk and mitigation factors on and around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the steps of the medication administration process was followed for one of three employees (unlicensed personnel (ULP)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on July 14, 2025, at 10:50 a.m., consultant (C)-C stated the	02320		

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02320	Continued From page 88 licensee provided medication management to residents at the facility. On July 15, 2025, at 5:59 a.m., the surveyor observed ULP-F provide scheduled medication administration for R2. ULP-F removed R2's alendronate 35 milligrams (mg) bubble pack (prepackaged medication set up per pharmacy) from the medication cart, punched out one tablet of alendronate from the bubble pack into a paper cup, and placed the bubble pack back into the medication cart. ULP-F stated the licensee's internet and online documentation system was down after 11:00 p.m. last night (July 14, 2025), however, ULP-F stated ULP-F was aware R2 was administered alendronate 35 mg every Tuesday morning and referred the surveyor to the label on the bubble pack. ULP-F proceeded to R2's room and administered alendronate 35 mg to R2. ULP-F stated ULP-F would document alendronate 35 mg on the next scheduled shift ULP-F was scheduled to work and would inform the daytime ULP alendronate was administered to R2. ULP-F further stated ULP-F did not know the licensee's back up plan to administer medications if the online documentation system was down. On July 15, 2025, at 6:41 a.m., ULP-G arrived at the facility and accessed the licensee's online documentation system via ULP-G's smart phone. ULP-F stated ULP-F did not have a smart phone and was not able to access the licensee's online documentation system. On July 15, 2025, at 8:25 a.m., C-C stated C-C was not sure if the licensee had a back up plan if the internet and online documentation system was down.	02320		

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02320	Continued From page 89 On July 15, 2025, at 12:54 p.m., clinical nurse supervisor (CNS)-B stated ULPs were not supposed to administer medications unless ULPs had access to the online documentation system or a printed medication administration record (MAR) for the resident. CNS-B further stated ULP-F was supposed to contact the registered nurse (RN) on call for guidance if ULP-F was unable to access the online documentation system and the RN would have provided a printed MAR. CNS-B further stated ULPs were trained on the five rights of medication administration, including checking the medication label with the resident's MAR, to be completed three times, and once ULPs administered the medication documentation was completed within 10 minutes. The licensee's Medication Management Services-Med (medication) Aide policy dated August 26, 2020, indicated a RN (registered nurse) must instruct the med (medication) aide (ULP) on the following medications administration tasks and deem the medication aide competent before delegating the medication administration task to the med aide: -the complete procedure of checking a client's (resident's) MAR; -the procedure related to the type of medication administration; -the preparation of medication for administration; -the reminder to self-administer medications; and -the documentation after assistance with medication reminder or medication administration, of the date, time, dosage, and method of administration of all medications, or the reason for not assisting with medication administration as ordered, and the initials of the	02320		

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02320	Continued From page 90 nurse or authorized person who assisted or administered and observed the same [sic]. The licensee's Medication Reminders, Medication Setups policy dated August 26, 2020, indicated documentation of a medication reminder, medication assistance or medication administration will be completed immediately after that task (medication administration) has been performed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

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0 000	Initial Comments ***ATTENTION*** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30224016-0 On July 14, 2025, through July 16, 2025, 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 15 residents; 15 receiving services under the Assisted Living Facility with Dementia Care license. An immediate correction order was identified on July 16, 2025, issued for SL30224016-0, tag identification 0110. The licensee took action on July 16, 2025, to mitigate the risk; however, the scope and level remains at level 3/Widespread (I). An immediate correction order was identified on July 16, 2025, issued for SL30224016-0, tag identification 1290. The licensee took action on	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 000	Continued From page 1 July 16, 2025, to mitigate the risk; however, the scope and level remains at level 3/Widespread (I).	0 000		
0 100 SS=F	144G.10 Subdivision 1 License required (a)(1) Beginning August 1, 2021, no assisted living facility may operate in Minnesota unless it is licensed under this chapter. (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b) The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). If a portion of a licensed assisted living facility building is utilized by an unlicensed entity or an entity with a license type not granted under this chapter, the licensed assisted living facility must ensure there is at least a vertical two-hour fire barrier as defined by the National Fire Protection Association Standard 101, Life Safety Code, between any licensed assisted living facility areas and unlicensed entity areas of the building and between the licensed assisted living facility areas and any licensed areas subject to another license type. (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a	0 100		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30224	A. BUILDING: _____ B. WING _____	07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY ASSISTED LIVING	523 ARNOLD AVENUE SOUTH THIEF RIVER FALLS, MN 56701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 100	Continued From page 2 campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided. (e) Upon approving an application for an assisted living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to demonstrate legal responsibility for the control and operation of the facility when the licensee rented out use of the facility space to be used for operating a daycare. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 100		

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VALLEY ASSISTED LIVING	523 ARNOLD AVENUE SOUTH THIEF RIVER FALLS, MN 56701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 100	Continued From page 3 The findings include: On July 14, 2025, at 10:28 a.m., the surveyor arrived at the licensee and entered door number six. A construction worker stopped the surveyor, stated the wing of the building was under construction to build a daycare, and directed the surveyor to the other side of the building. During the entrance conference on July 14, 2025, at 10:47 a.m., consultant (C)-C stated the licensee was familiar with the current minimum assisted living requirements. The licensee's Quality Meeting Notes dated May 14, 2025, indicated the ribbon cutting ceremony target date for the daycare was the last week in July. The licensee's Quality Meeting Notes dated June 11, 2025, indicated the new target date was August 11, 2025, for opening the daycare. A ribbon cutting ceremony the week of August 4, 2025, through August 8, 2025. During facility tour on July 14, 2025, at 1:47 p.m., C-C stated the licensee had rented out a wing of the facility, which was under construction, and the spaced was going to be used to run a daycare. C-C stated the wing rented out was in the same building as the licensee and was accessible to any staff, residents, or visitors. C-C further stated C-C did not believe the licensee had filed for a variance with the Minnesota Department of Health (MDH). On July 14, 2025, at 2:01 p.m., clinical nurse supervisor (CNS)-B stated the area under construction was rented out to have a daycare for	0 100		

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VALLEY ASSISTED LIVING	523 ARNOLD AVENUE SOUTH THIEF RIVER FALLS, MN 56701

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0 100	Continued From page 4 a private company, and the wing was the previous secured (required a keypad to enter and exit) unit no longer in use by the licensee. On July 15, 2025, at 9:55 a.m., administrative assistant (AA)-A stated the wing under construction was leased (rented) out to operate a daycare. On July 15, 2025, at 2:28 p.m., construction consultant (CC)-R stated CC-R was unsure if the licensee had applied for a variance with MDH, however, CC-R stated CC-R had understood the licensee would be issued a "different" licensee on July 24, 2025, or July 25, 2025, to operate a daycare in the building. On July 15, 2025, at 2:29 p.m., the MDH engineer surveyor stated the wing for the daycare was accessible through a fire door, and the daycare wing was in the same building where the assisted living with dementia care licensee was located. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 100		
0 110 SS=I	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director who is licensed or permitted by the Board of Executives for Long Term Services and Supports and affiliated as the director of record with the board.	0 110		

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0 110	Continued From page 5 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employment of a licensed assisted living director (LALD), licensed by the Board of Executives for Long Term Services and Supports (BELTSS). This had the potential to affect all residents and staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: This resulted in an immediate correction order issued on July 16, 2025. The licensee held an assisted living facility with dementia care (ALFDC) license issued on November 1, 2024, through October 31, 2025. During the entrance conference on July 14, 2025, at 10:44 a.m., consultant (C)-C stated previous (P)LALD-O was listed as the current LALD for the licensee and PLALD-O had worked for the license through the previous management company that is no longer affiliated with the licensee. On July 14, 2025, at 11:22 a.m., the BELTSS website indicated PLALD-O was listed as the director of record for the facility effective October 9, 2024.	0 110		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY ASSISTED LIVING	523 ARNOLD AVENUE SOUTH THIEF RIVER FALLS, MN 56701

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0 110	Continued From page 6 On July 14, 2025, at 1:06 p.m., clinical nurse supervisor (CNS)-B stated PLALD-O was no longer employed with the licensee and administrator (A)-N was going to be the LALD for the licensee. On July 15, 2025, at 9:48 a.m., administrative assistant (AA)-A stated AA-A had never met or seen PLALD-O in the building or spoke with PLALD-O since AA-A started in January 2025. On July 14, 2025, at 1:37 p.m., the BELTSS website indicated C-C was listed as the director of record for the licensee effective June 8, 2025, and expired July 1, 2025. On July 14, 2025, at 1:40 p.m., the BELTSS website indicated A-N had a shared residency permit effective October 10, 2023, and expired October 9, 2024, for the licensee. On July 14, 2025, at 1:42 p.m., C-C stated C-C was going to be LALD mentor for A-N, however, A-N's BELTSS application was denied, and the licensee was in the process of completing an appeal with BELTSS. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 110		
0 420 SS=I	144G.40 Subdivision 1 Responsibility for housing and services The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but	0 420		

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0 420	Continued From page 7 are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide sufficient management, control, and operation of the housing and services provided by the facility. This had the potential to affect all residents. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 14, 2025, at 10:47 a.m., consultant (C)-C stated the licensee was familiar with the current minimum assisted living requirements. The licensee held an assisted living license with dementia care license effective November 1, 2024, with an expiration date of October 31, 2025. The licensee's renewal "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified an affirmative checkmark next to the statement, "I declare that,	0 420		

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0 420	Continued From page 8 as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659, governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." Another checkmark was noted at the statement, "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH (Minnesota Department of Health), in writing, of any changes to this information as required." Page six was electronically signed by the owner/authorized agent on October 1, 2024. As a result of this survey, the following orders were issued under 0100, 0110, 0470, 0480, 0490, 0640, 0650, 0660, 0680, 0775, 0800, 0810, 0830, 1290, 1460, 1500, 1540, 1550, 1620, 1710, 1760, 1770, 1790, 1820, 1880, 1930, 1940, 1950, 1960, 1970, 2040, and 2320, which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 420		

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0 470	Continued From page 9	0 470		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the clinical nurse supervisor (CNS) developed and implemented a staffing plan to determine staffing levels to meet the needs of all residents. This had the potential to affect all residents, staff, and visitors.	0 470		

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0 470	Continued From page 10 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living license with dementia care license effective November 1, 2024, with an expiration date of October 31, 2025. The facility was licensed for a capacity of 43 and had a current census of 15 residents. During the entrance conference on July 14, 2025, at 10:47 a.m., consultant (C)-C stated the licensee was familiar with the current minimum assisted living requirements. On July 14, 2025, at 1:10 p.m., CNS-B stated the licensee scheduled the following unlicensed personnel (ULPs) for each shift: -day shift 7:00 a.m. through 2:00 p.m., two ULPs were scheduled; -evening shift 2:00 p.m. through 10:00 p.m., one ULP was scheduled; and -night shift 10:00 p.m. through 7:00 a.m., one ULP was scheduled. On July 16, 2025, at 5:28 a.m., C-C emailed (electronic mail) C-C spoke with the previous management company and confirmed a staffing plan had not been completed. On July 16, 2025, at 1:03 p.m., CNS-B stated CNS-B was not sure if a staffing plan had been developed, and CNS-B was not aware of the	0 470		

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0 470	Continued From page 11 staffing plan requirement. CNS-B further stated administrator (A)-N was responsible for the licensee's staffing needs and scheduling of staff. No further information was provided. 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 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (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; (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; (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	0 480		

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0 480	Continued From page 12 clean equipment and dishes are air dried in a manner that prevents contamination before storage; (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; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (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 (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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	0 480		

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0 480	Continued From page 13 has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 14, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 490 SS=F	144G.41 Subdivision 1b Minimum requirements; other required services All assisted living facilities must offer to provide or make available the following services to residents: (1) weekly housekeeping; (2) weekly laundry service; (3) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (4) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (5) provide culturally sensitive programs; and (6) have a daily program of social and recreational activities that are based upon	0 490		

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0 490	Continued From page 14 individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have daily programs of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs. This had the potential to affect all 15 residents at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 14, 2025, at 10:53 a.m., consultant (C)-C stated to C-C's understanding the licensee had provided a daily program of social and recreational activity for residents. During a self-guided tour on July 14, 2025, from 12:05 p.m. until 12:15 p.m., the surveyor observed a bulletin board hanging in the hallway. The sign on the bulletin board indicated activities, then listed bingo on Thursday's at 3:00 p.m. with volunteers, and Sunday's at 2:00 p.m. with an unknown individual. No other activities were posted on the bulletin board.	0 490		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY ASSISTED LIVING	523 ARNOLD AVENUE SOUTH THIEF RIVER FALLS, MN 56701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 490	Continued From page 15 During the survey on July 14, 2025, through July 16, 2025, the surveyor did not observe any planned or offered activities for residents to attend. The surveyor observed residents sitting in the hallway or watching television in the dining room, while some residents remained in their rooms most of the day. On July 15, 2025, at 9:35 a.m., administrative assistant (AA)-A stated the licensee did not have an activity coordinator, nor had the licensee developed an activity calendar. AA-A stated the licensee was doing the best to provide an activity such as bingo or offer a church service. On July 16, 2025, at 12:58 p.m., clinical nurse supervisor (CNS)-B stated the licensee use to have an activity calendar posted in the kitchen, however, the kitchen was under construction and not accessible by residents or staff. CNS-B further stated administration was working on an activities program for residents and the licensee's activity program was "poor." CNS-B further stated CNS-B was new to the CNS role and was using the survey process for an opportunity to learn. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 490		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by:	0 640		

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0 640	Continued From page 16 (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post required content in common areas to include posting the 911 emergency number in common areas at the assisted living. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During a self-guided tour on July 14, 2025, from 12:05 p.m., until 12:15 p.m., the surveyor did not observe 911 posted in any common areas of the assisted living. On July 15, 2025, at 6:16 a.m., unlicensed personnel (ULP)-F stated 911 was posted on the bulletin board in the ULP/nurse office, however, ULP-F stated residents or visitors would not be able to observe the 911 posting.	0 640		

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0 640	Continued From page 17 On July 15, 2025, at 9:35 a.m., administrative assistant (AA)-A stated the licensee only posted the 911 number in the ULP/nurse office that was not accessible by any residents or visitors. The licensee's Required Postings in Licensed Assisted Living Policy dated February 2022, indicated 911 Emergency [sic] number in common areas near telephones would be posted in a conspicuous place. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (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, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health	0 650		

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0 650	Continued From page 18 screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained the required content for one of two employees (registered nurse (RN)-D). This practice resulted in a level two violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on July 14, 2025, at 11:32 a.m., consultant (C)-C stated C-C was aware of required contents in an employee record. RN-D was hired on August 21, 2018, and provided direct care and RN on call services for supervision to residents and staff at the assisted living effective August 1, 2021. RN-D's employee record lacked annual performance reviews, and a job description. On July 16, 2025, at 1:08 p.m., clinical nurse supervisor (CNS)-B stated the licensee was behind on scanning paper documents into employee records and the license likely had	0 650		

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0 650	Continued From page 19 RN-D's annual performance review and job description filled out on paper, however, CNS-B was unable to locate. On July 16, 2025, at 9:34 a.m., C-C stated C-C had provided the surveyor with all the licensee's documentation C-C was able to locate. The licensee's Employee Required Documents policy dated March 22, 2022, indicated employee records included a current job description, including qualifications, responsibilities, and identification of staff persons providing supervision. In addition, employee records included documentation of annual performance reviews that identify areas of improvement needed and training needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (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 covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of	0 660		

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0 660	Continued From page 20 the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and Minnesota Department of Health (MDH), including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of two employees (unlicensed personnel (ULP)-H). This practice resulted in a level two violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on July 14, 2025, at 10:47 a.m., consultant (C)-C stated the licensee was familiar with the current minimum assisted living requirements. The licensee's Facility TB Risk Assessment Worksheet for Health Care Settings Licensed by MDH was completed on May 31, 2025, and the facility was determined to be a low risk level. ULP-H was hired on April 30, 2025, to provide direct care services to residents at the assisted	0 660		

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0 660	Continued From page 21 living with dementia care facility. On July 15, 2025, at 3:57 p.m., the surveyor observed ULP-H provide scheduled afternoon medication administration for R6. ULP-H's employee record contained a negative Baseline TB Screening Tool for Healthcare Workers (HCWs) dated June 20, 2025. ULP-H's employee record lacked evidence of completion of a two-step TST or other evidence of TB screening such as a blood test. On July 16, 2025, at 1:22 p.m., clinical nurse supervisor (CNS)-B stated ULP-H was supposed to have completed a two-step TST upon hire, however, the licensee was aware ULP-H had not completed a two-step TST. CNS-B further stated the license previously administered two-step TST at the facility, however, the licensee could no longer obtain tuberculin to complete the two-step TSTs and referred new employees to go to the local clinic to complete the two-step TST. The licensee's TB and Staff Screening policy dated June 2021, indicated new staff shall have a two-step TST conducted with results document on the Baseline TB Screening Tool for HCWs. In addition, a blood test shall be an acceptable substitute for a two-step TST. The Regulations for TB Control in Minnesota Health Care Settings dated July 2013, indicated a baseline TB screening is required for all HCWs upon hire, and included administering a two-step TST or single blood draw to screen for active TB. The MDH TB Screening and Education Requirements for Assisted Living Facilities and	0 660		

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0 660	Continued From page 22 Home Care Providers dated February 3, 2022, indicated baseline TB screening is required at the time of hire for all health care personnel in Minnesota. Baseline TB screening includes assessing for current symptoms of active TB disease; assessing TB history; and testing for the presence of infection with Mycobacterium TB by administering either a two-step TB skin test or a single TB blood test. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are	0 680		

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0 680	Continued From page 23 allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and post a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. In addition, the licensee failed to ensure the missing resident plan was reviewed quarterly. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 14, 2025, at 10:47 a.m., consultant (C)-C stated the licensee was familiar with the current minimum assisted living requirements. During a self-guided tour on July 14, 2025, from 12:05 p.m. until 12:15 p.m., the surveyor did not observe signage posted in any common areas of the assisted living of where to locate the licensee's EPP. The licensee's electronic EPP dated June 1,	0 680		

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0 680	Continued From page 24 2024, signed by administrator (A)-N, lacked the following content and/or policies and procedures to address: - an EPP available for all staff, residents, and volunteers to access; - annual review of the EPP; - a missing resident plan that was reviewed quarterly: Missing Resident policy provided was reviewed January 2024, July 2024, and July 2025, respectively; - a description of the population served by the licensee; - the medical record documentation system the facility has developed to preserve resident information security and availability of records; - memorandums of agreement (MOAs) with other facilities; and - must conduct exercises to test the EPP at least twice per year, including unannounced staff drills using the EPP. On July 15, 2025, at 6:16 a.m., unlicensed personnel (ULP)-F stated the licensee had no signage posted for the licensee's EPP and ULP-H had thought the EPP was kept in the office. On July 15, 2025, at 8:25 a.m., C-C stated C-C was not sure if an EPP binder was accessible for residents, staff, or visitors. On July 15, 2025, at 9:34 a.m., administrative assistant (AA)-A stated the licensee did not post any EPP signage of where the EPP binder was located. AA-A further stated AA-A found the EPP binder in front of the nurse's office, however, AA-A stated it (EPP binder) was old and from 2019. On July 15, 2025, at 9:57 a.m., AA-A stated AA-A had never done anything with the licensee's EPP	0 680		

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0 680	Continued From page 25 and AA-A was not sure who was responsible for reviewing and updating the EPP annually. AA-A further stated AA-A was not sure how often the missing resident was reviewed or if the licensee had completed any test exercises. AA-A stated AA-A was not sure how staff, residents, or visitors would access the current EPP if it was stored on a computer or online. AA-A further stated AA-A had recalled the licensee had discussed MOAs, however, AA-A was not sure where the MOAs were located. On July 16, 2025, at 9:34 a.m., C-C stated C-C had provided the surveyor with all the licensee's documentation C-C was able to locate. On July 16, 2025, at 12:48 p.m., clinical nurse supervisor (CNS)-B stated CNS-B was not sure who was responsible for the EPP, however, CNS-B had thought it was the responsibility of the administration. The licensee's Emergency Preparedness Program dated July 2025, indicated the facility will develop a facility-specific emergency plan to be activated according to its emergency threat and will review it (EPP) annually. In addition, training will occur minimally each year and the facility must conduct exercises to test the emergency plan at least twice per yea, including unannounced staff drills using the emergency procedures. The licensee's Missing Resident policy dated July 2025, did not address how often the policy would be reviewed. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110, Subp. 4, effective October 2022, the assisted living director and clinical	0 680		

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0 680	Continued From page 26 nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	0 800		

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0 800	Continued From page 27 Based on observation and interview, the licensee failed to maintain 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 addition, the licensee failed to comply with Minnesota State Fire Code in Minnesota Rules chapter 7511. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 15, 2025, at 1:45 p.m., surveyor toured the facility with construction consultant (CC)-R. The following was observed: GENERAL MAINTENANCE: Office window had an air conditioner installed and was missing the weather proofing strips along the side leaving it exposed to the outside. Resident room (unoccupied) #11 had the wood finishes coming off the closet door. Resident room (Occupied) #14 had holes in the carpet.	0 800		

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0 800	Continued From page 28 Resident room (unoccupied) #15 was under construction due to water damage done to the ceiling. CC-R stated they understood the above-listed deficiencies. Electrical Hazards: On August 5, 2025, at 10:30 a.m., it was observed that there was a portable space heater that was being powered through an extension cord resident room #13. The plug end of the extension cord had been replaced from the original manufacturer plug end. Space heaters shall only be used in nonsleeping staff and employee areas. Extension cords shall be maintained in good condition without splices, deterioration or damage. Ammunition components storage: On August 5, 2025, at 10:30 a.m., a 100-count box of large rifle primers was observed on top of a folding table in resident room #13. The storage of black powder, smokeless propellants, and small arms primers is prohibited. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms;	0 810		

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0 810	Continued From page 29 (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 810		

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0 810	Continued From page 30 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 15, 2025, at 2:50 p.m. consultant (C)-C was unable to provide documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. C-C stated that she understood the requirements of maintaining this plan. TRAINING: The licensee failed to provide evacuation training to staff and residents as required. C-C stated that she understood the requirements for training the employees and residents. DRILLS: The licensee failed to conduct evacuation drills for employees as required. C-C stated that she understood the requirements for employees conducting evacuation drills twice per year per shift with at least one evacuation drill every other month. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 830 SS=F	144G.45 Subd. 3 Local laws apply	0 830		

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0 830	Continued From page 31 Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation, record review and interview, the licensee failed to comply with all state and local governing laws, and codes for fire safety, building, and zoning requirements. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 15, 2025, at 2:30 p.m., survey staff toured the facility with construction consultant (CC)-R. At the time of the survey, the kitchen, dining and activities rooms was under various forms of construction. CC-R stated that they had to renovate these rooms due to some water damage and a newly added on daycare added to the facility.	0 830		

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0 830	Continued From page 32 CC-R was not able to provide a floorplan at the time of survey, so the extent of construction/ renovation was not able to be determined. Building permits and approvals and MDH approvals for renovation were not able to be provided. Facilities undergoing construction and renovation must get proper approvals from MDH and MN DLI or local building authority prior to starting construction or renovation. CC-R stated he understood no residents could occupy the house and stated there were no plans to move anyone into that space until it was finished. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 830		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to	0 970		

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0 970	Continued From page 33 affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee's undated Assisted Living with Dementia Care Service Contract (assisted living contract), included the following clause that a resident would waive the facility's liability for health, safety, or personal property of the resident: -Page 11: number 19: Resident may park their personal vehicle in the parking lot adjacent to the facility. Facility assumes no responsibility for the security or safety of the vehicles or for the personal property kept in the vehicles. On July 15, 2025, at 9:50 a.m., administrative assistant (AA)-A stated to AA-A's knowledge the same contract was used for all residents. AA-A further stated the licensee was not responsible for resident's personal property in a resident's vehicle on the licensee's premises, and AA-A was not aware a waiver of liability could not be in the assisted living contract. On July 16, 2025, at 12:50 p.m., clinical nurse supervisor (CNS)-B stated administrator(A)-N was responsible for resident contracts and CNS-B was not aware the assisted living contract listed a waiver of liability.	0 970		

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0 970	Continued From page 34 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current employee records contained all the required content to include a current background study clearance letter for three of 13 employees (unlicensed personnel (ULP)-I, ULP-L, dietary aide (DA)-K). In addition, the licensee failed to ensure the employee's current background study clearance was affiliated with the correct health care facility identification (HFID) for two of 10 employees (ULP-J, ULP-M) This had the potential to affect all residents living within the facility.	01290		

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01290	Continued From page 35 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: This resulted in an immediate correction order on July 16, 2025. During the entrance conference on July 14, 2025, at 11:32 a.m., consultant (C)-C stated C-C was aware of required contents in an employee record. NO BACKGROUND STUDY ULP-I ULP-I was hired on March 12, 2022, to provide direct care services to residents at the facility. On July 14, 2025, at 2:53 p.m., the surveyor observed ULP-I working independently at the medication cart. ULP-I stated ULP-I worked full time for the licensee. The licensee's weekly schedule dated June 22, 2025, through July 19, 2025, indicated ULP-I was scheduled to work 20 out of 84 scheduled shifts. ULP-I's Direct Deposit dated July 11, 2025, indicated ULP-I had worked 106.11 hours from June 22, 2025, through July 5, 2025. ULP-L	01290		

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01290	Continued From page 36 ULP-L was hired on August 30, 2024, to provide direct care services to residents at the facility. A paystub was requested for ULP-L, however, was not provided. DA-K DA-K was hired on an unknown date to assist with providing dining services to residents at the facility. DA-K's Direct Deposit dated July 11, 2025, indicated DA-K had worked 4.90 hours from June 22, 2025, through July 5, 2025. ULP-I, ULP-L, and DA-K's employee records lacked a current cleared background study. WRONG AFFILIATION ULP-J ULP-J was hired on March 12, 2022, to provide direct care services to residents at the facility. On July 14, 2025, at 2:52 p.m., the surveyor observed ULP-J working independently at the facility. ULP-J stated ULP-J worked full time for the licensee and usually worked the overnight shift. The licensee's Labor Distribution dated December 22, 2024, through March 15, 2025, indicated ULP-J had worked 39.17 hours for the licensee. ULP-M ULP-M was hired on October 4, 2024, to provide direct care services to residents at the facility. A paystub was requested for ULP-M, however, was not provided.	01290		

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01290	Continued From page 37 ULP-J and ULP-M's employee records contained a background study with the HFID of a sister facility location and not the correct HFID for the licensee. On July 15, 2025, from 10:28 a.m. through 10:30 a.m., the surveyor reviewed the licensee's NETStudy 2.0 roster with administrative assistant (AA)-A. AA-A stated ULP-I, ULP-L, DA-K, ULP-J, and ULP-M were current employees for the licensee with out direct supervision. On July 15, 2025, at 11:42 a.m., C-C stated administrator (A)-N was responsible for completion of employee background studies. C-C further stated no employee should be working on the floor with residents without a current cleared background study. On July 15, 2025, 1:09 p.m., C-C stated C-C searched the NETStudy 2.0 website for ULP-I, ULP-L, and DA-K names, however, the no results were found. The licensee's Background Study policy dated October 2010, indicated documentation of eligibility will be obtained from the Department of Human Services and will be placed in the employee's personnel record. Continuous Direct Supervision defined in NETStudy 2.0 System User Manual Updated July 7, 2023, page 7: Continuous, Direct Supervision - An individual is within sight or hearing of the program's supervising individual to the extent that the program's supervising individual is capable at all times of intervening to protect the health and safety of the persons served by the program. Direct Contact Services - Providing face-to-face	01290		

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01290	Continued From page 38 care, training, supervision, counseling, consultation, or medication assistance to persons served by the entity. Supervision defined in, NETStudy 2.0 System User Manual Updated July 7, 2023, page 53: Supervision Status Study subjects must be under continuous, direct supervision until the study subject is determined eligible of until the entity is notified by DHS that the study subject may provide unsupervised services while the background study is being completed. The supervision status is shown in the "Supervision Required" column for convenience. However, programs are instructed to rely on background study notices for supervision status and other background study determination information. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors (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). (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	01460		

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01460	Continued From page 39 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide staff orientation to assisted living licensing requirements and regulations for one of four employees (dietary aide (DA)-P). This had the potential to affect all 15 residents. This practice resulted in a level two violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include:	01460		

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01460	Continued From page 40 During the entrance conference on July 14, 2025, at 11:32 a.m., consultant (C)-C stated C-C was aware of required contents in an employee record. DA-P was hired on July 3, 2019, to assist with providing dining services to residents at the facility on August 1, 2021. DA-P's employee record indicated DA-P completed Home Care Orientation on June 11, 2019. DA-P's employee record lacked documentation to indicate DA-P completed orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. On July 16, 2025, at 9:34 a.m., C-C stated C-C had provided the surveyor with all the licensee's documentation C-C was able to locate. On July 16, 2025, at 1:30 p.m., clinical nurse supervisor (CNS)-B stated all staff were assigned to complete the same training via Educare (online training platform), however, if the education was not completed it would not be listed on the employee's Educare transcript. The licensee's Orientation and Annual Training Requirements-Including Dementia Training policy dated March 2022, indicated all staff providing and supervising direct services must complete an orientation to assist living facility licensing requirements and regulations before providing assisted living services to residents. No further information was provided.	01460		

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01460	Continued From page 41 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460		
01500 SS=F	144G.63 Subd. 5 Required annual training (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: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (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; (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; (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 (6) the principles of person-centered planning and service delivery and how they apply to direct	01500		

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01500	Continued From page 42 support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. 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: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an employee received all the required content for annual training for each 12 months of employment for one of one employee (registered nurse (RN)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30224	A. BUILDING: _____ B. WING _____	07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY ASSISTED LIVING	523 ARNOLD AVENUE SOUTH THIEF RIVER FALLS, MN 56701

(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
01500	Continued From page 43 The findings include: During the entrance conference on July 14, 2025, at 11:32 a.m., consultant (C)-C stated C-C was aware of required contents in an employee record. RN-D was hired on August 21, 2018, and provided direct care and RN on call services for supervision to residents and staff at the assisted living effective August 1, 2021. RN-D's employee record lacked documentation of review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures as part of annual training provided by the licensee. On July 16, 2025, at 9:34 a.m., C-C stated C-C had provided the surveyor with all the licensee's documentation C-C was able to locate. On July 16, 2025, at 1:08 p.m., clinical nurse supervisor (CNS)-B stated the licensee was "probably" behind on annual training with all required topics to cover for all staff. The licensee's Orientation and Annual Training Requirements-Including Dementia Training policy dated March 2022, indicated content of required annual training included review of facility's policies and procedures related to assisted living provision of assisted living services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		

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01540	Continued From page 44	01540		
01540 SS=F	144G.64 (a) (3) Training in Dementia, Mental Illness, and De- (3) for assisted living facilities with dementia care, direct-care staff must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, the 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 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; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two employees (registered nurse (RN)-D, unlicensed personnel (ULP)-H) received the required amount of mental illness and de-escalation training within the required time frame. 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	01540		

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VALLEY ASSISTED LIVING	523 ARNOLD AVENUE SOUTH THIEF RIVER FALLS, MN 56701

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01540	Continued From page 45 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility with dementia care (ALFDC) license issued on November 1, 2024, through October 31, 2025. During the entrance conference on July 14, 2025, at 11:32 a.m., consultant (C)-C stated C-C was aware of required contents in an employee record. RN-D RN-D was hired on August 21, 2018, and provided direct care and RN on call services for supervision to residents and staff at the assisted living effective August 1, 2021. The licensee's Labor Distribution dated December 22, 2024, through March 15, 2025, indicated RN-D had worked over 1,340 hours for the licensee. RN-D's employee record lacked RN-D had completed any training mental illness or de-escalation by July 1, 2025. ULP-H ULP-H was hired on April 30, 2025, to provide direct care services to residents at the facility. On July 15, 2025, at 3:57 p.m., the surveyor observed ULP-H provide scheduled afternoon medication administration for R6.	01540		

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01540	Continued From page 46 The licensee's Weekly schedule dated June 22, 2025, through July 12, 2025, indicated ULP-H had worked 126 hours for the licensee. ULP-H's employee transcript indicated ULP-H completed one (1) hour of Mental Illness-Response Strategies on May 20, 2025. ULP-H's employee record lacked ULP-H had completed two (2) hours of mental illness and de-escalation training by July 1, 2025. On July 16, 2025, at 1:13 p.m., clinical nurse supervisor (CNS)-B stated mental illness, de-escalation, and annual dementia training were supposed to be assigned to each employee on Educare (online training platform), however, CNS-B stated CNS-B was not sure if the topics were assigned to each employee. On July 16, 2025, at 1:30 p.m. CNS-B stated all employees were "due" to complete mental illness, de-escalation, and dementia trainings. On July 16, 2025, at 9:34 a.m., C-C stated C-C had provided the surveyor with all the licensee's documentation C-C was able to locate. On July 17, 2025, at 8:14 p.m., C-C emailed (electronic mail) C-C was unable to locate a policy for mental illness and de-escalation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01550 SS=F	144G.64 (a) (4) Training in Dementia, Mental Illness, and De-	01550		

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01550	Continued From page 47 (4) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on 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, and 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; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure three of three employees (housekeeper (HSKP)-E, dietary aide (DA)-P, DA-K) received the required amount of mental illness and de-escalation in the required time frame. In addition, the licensee failed to ensure two of two employees (HSKP-E, DA-P) received annual dementia training for each 12 months of employment after hire. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	01550		

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01550	Continued From page 48 During the entrance conference on July 14, 2025, at 11:32 a.m., consultant (C)-C stated C-C was aware of required contents in an employee record. HSKP-E HSKP-E was hired on June 22, 2023, to provide housekeeping to residents at the facility. Throughout the survey on July 14, 2025, through July 16, 2025, the surveyor observed HSKP-E cleaning the facility and resident apartments. DA-P DA-P was hired on July 3, 2019, to assist with providing dining services to residents at the facility on August 1, 2021. DA-K DA-K was hired on an unknown date to assist with providing dining services to residents at the facility. HSKP-E, DA-P, and DA-K's employee records lacked two hours of initial training on mental illness and de-escalation. In addition, HSKP-E and DA-P's employee records lacked two hours of annual dementia training for each 12 months of employment. On July 16, 2025, at 9:34 a.m., C-C stated C-C had provided the surveyor with all the licensee's documentation C-C was able to locate. On July 16, 2025, at 1:13 p.m., clinical nurse supervisor (CNS)-B stated mental illness, de-escalation, and annual dementia training were supposed to be assigned to each employee on Educare (online training platform), however,	01550		

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01550	Continued From page 49 CNS-B stated CNS-B was not sure if the topics were assigned to each employee. On July 16, 2025, at 1:30 p.m. CNS-B stated all employees were "due" to complete mental illness, de-escalation, and dementia trainings. The licensee's Orientation and Annual Training Requirements-Including Dementia Training policy dated March 2022, indicated staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least 2 (two) hours of training on topics related to dementia care for each 12 months of employment thereafter. The policy did not address training on mental illness or de-escalation. On July 17, 2025, at 8:14 p.m., C-C emailed (electronic mail) C-C was unable to locate a policy for mental illness and de-escalation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01550		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on	01620		

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01620	Continued From page 50 which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.	01620		

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01620	Continued From page 51 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the registered nurse (RN) failed to conduct a comprehensive reassessment for one of two residents (R4). This practice resulted in a level two violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on July 14, 2025, at 1:08 p.m., clinical nurse supervisor (CNS)-B stated CNS-B completed a preadmission, 14-day, 90-day, and change of condition assessments on residents when CNS-B was onsite at the facility during the day. R4's diagnoses included diabetes, hypertension (HTN- high blood pressure), and depression. R4's Service Plan (Waiver)- Addendum to Contract dated May 20, 2025, indicated R4's services included medication administration, blood glucose checks, assistance with bathing grooming, dressing, and light housekeeping. On July 15, 2025, at 11:00 a.m., the surveyor observed unlicensed personnel (ULP)-G administer scheduled morning medication for R4. R4's Resident Profile Notes included the following	01620		

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01620	Continued From page 52 entries: -June 20, 2025, at 2:02 p.m., urine brought to clinic for suspected UTI (urinary tract infection)- positive results- order for antibiotic written by CNS-B; -June 25, 2025, at 7:33 a.m., R4 reported to ULP R4 does not eat all day long, R4 seems more depressed than usual written by ULP-F; -July 6, 2025, at 7:20 a.m., R4 was laying in bed, R4 asked for a knife to cut the cake that was sitting on R4's chest, also R4 said other bizarre things. R4 also said R4 went with R4's brother yesterday to visit the relatives at his house, however, ULP-F confirmed with staff that R4 never went over there written by ULP-F; -July 6, 2025, at 4:38 p.m., staff updated nurse this morning that R4 had slipped and fell out of R4's chair. No injuries no concerns. Vitals WNL (within normal limits). Family contacted per staff written by RN-D. -July 7, 2025, at 6:58 a.m., R4 wants to be fed in bed, doesn't want the ambulance called with continued weakness. When ULP-F helped R4 in the bathroom, R4 had to sit down several times before ULP-F could finish wiping R4 written by ULP-F; -July 7, 2025, at 7:39 a.m., staff called this am (morning) to report resident was co [sic] and off. R4 refused to go to ER. R4 has an appointment today written by RN-D; -July 7, 2025, at 9:51 a.m., noted recent diagnosis of UTI with antibiotics- and noted confusion written by CNS-B; and -July 12, 2025, at 6:21 a.m., R4 stated R4 was at (person's name) house yesterday, which R4 wasn't there. Also, R4 had a chicken salad sandwich rolled up in R4's blanket, ULP-F unrolled R4's blanket to show R4 that nothing was there written by ULP-F.	01620		

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01620	Continued From page 53 R4's Assessment dated May 20, 2025, indicated R4 had a history of UTI concerns, had generalized weakness and balance problem, had a history of major chronic depression, and oriented to person, place, and time of day. R4's record lacked a change of condition assessment after R4 was diagnosed with a UTI in June and July 2025, respectively, had a fall, R4 had begun to become more weak, depressed, and confused. On July 16, 2025, at 1:44 p.m., CNS-B stated falls, consumption of less food, new diagnosis, or feeling depressed would all trigger a change of condition assessment to be completed on a resident. CNS-B further stated CNS-B was not sure who documented the changes in R4 as CNS-B was not aware of the changes, however, CNS-B was going to complete a referral for R4's change in condition since the last assessment on May 20, 2025. The licensee's Service Plan policy dated March 30, 2021, indicated ongoing client monitoring and reassessment must be conducted as needed based on changes in the needs of the resident and cannot exceed 90-days from the last date of the assessment. The monitoring and reassessment may be conducted at the client's (resident's) residence or through the utilization of telecommunication methods based on practice standards that meet the individual client's (resident's) needs. Change in client (resident) conditions may include: pattern in increase/decrease in ADL (activities of daily living), patterns of increase/decrease in behaviors, and falls. The licensee's Assessment-Schedules policy	01620		

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01620	Continued From page 54 dated June 3, 2015, indicated changes in client (resident) condition would be completed as indicted by an RN. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01710 SS=E	144G.71 Subd. 3 Individualized medication monitoring and reas A registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication management plan for each resident to include all required content for two of three residents (R2, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the	01710		

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01710	Continued From page 55 situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on July 14, 2025, at 10:50 a.m., consultant (C)-C stated the licensee provided medication management to residents at the facility. R2 R2's diagnoses included chronic obstructive pulmonary disease (COPD-difficult breathing), diabetes, and schizo-affective disorder. R2's Service Plan (Waiver)- Addendum to Contract dated September 25, 2024, indicated R2's services included medication administration five times per day. R2's prescriber orders dated September 12, 2024, included an order for budesonide 0.5 milligrams (mg)/ 2 milliliters (mL) inhale via nebulizer (a medical device that converts liquid medication into a fine mist) 0.5 mg/2 mL two times per day. On July 15, 2025, at 7:03 a.m., the surveyor observed unlicensed personnel (ULP)-G administer R2's scheduled morning medication. ULP-G poured R2's budesonide into R2's nebulizer chamber, handed R2 the nebulizer chamber, and turned on R2's nebulizer. ULP-G proceeded to leave R2's room and returned to the computer to document the administration of R2's medication. ULP-G stated R2 was able to independently complete the nebulizer administration and ULP-G would return to R2's room later to ensure R2 inhaled all the medication.	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30224	A. BUILDING: _____ B. WING _____	07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY ASSISTED LIVING	523 ARNOLD AVENUE SOUTH THIEF RIVER FALLS, MN 56701

(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
01710	Continued From page 56 R2's Individualized Medication Management Plan dated June 11, 2025, indicated med (medication) self-admin (administration) was not applicable and staff will administer all medications. R2's record lacked an updated Individualized Medication Management Plan for R2 to partially self-administer R2's budesonide. On July 16, 2025, at 1:38 p.m., clinical nurse supervisor (CNS)-B stated CNS-B should have updated R2's medication assessment as CNS-B had determined R2 could partially self-administer R2's budesonide via nebulizer. CNS-B stated medication assessments were typically updated every 90 days with the resident's assessment. R5 R5's diagnoses included schizoid personality disorder, anxiety, and hypertension (HTN-high blood pressure). R5's Service Plan (Waiver)- Addendum to Contract dated September 19, 2024, indicated R5's services included medication administration two times per day. R5's prescriber orders dated September 4, 2024, included an order for timolol 0.25% ophthalmic solution instill one drop into both eyes two times per day. On July 15, 2025, at 7:07 a.m., the surveyor observed ULP-G hand R5 the timolol eye drops, R5 self-administered one drop into each eye, and R5 returned the timolol bottle back to ULP-G. ULP-G stated R5 was able to self-administer eye drops and insulin, however, the licensee stored all R5's medications.	01710		

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
VALLEY ASSISTED LIVING	523 ARNOLD AVENUE SOUTH THIEF RIVER FALLS, MN 56701

(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
01710	Continued From page 57 R5's Individualized Medication Management Plan dated May 27, 2025, indicated R5 assists with insulin admin (administration) after staff set up and guide. R5's record lacked an updated Individualized Medication Management Plan for R5 to self-administer R5's eye drops. On July 16, 2025, at 1:20 p.m., CNS-B stated ULPs were trained to follow the instructions listed on the resident's medication administration record (MAR). CNS-B further stated if the instructions did not list self-administration, then ULPs should have administered the eye drop. The licensee's Medication Management Services-Medication Aide policy dated June 2021, indicated a RN must conduct a face-to-face resident assessment to determine what medication management services that will be provided to the resident. In addition, a RN must ensure that specific instructions in writing, for each client (resident) and document those instructions in the resident centered plan of care. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication 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	01760		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY ASSISTED LIVING	523 ARNOLD AVENUE SOUTH THIEF RIVER FALLS, MN 56701

(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
01760	Continued From page 58 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered per prescriber orders for two of two residents (R2, R4) observed during medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 14, 2025, at 10:50 a.m., consultant (C)-C stated the licensee provided medication management to residents at the facility. R2 R2's diagnoses included chronic obstructive pulmonary disease (COPD-difficult breathing), diabetes, and schizo-affective disorder.	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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VALLEY ASSISTED LIVING	523 ARNOLD AVENUE SOUTH THIEF RIVER FALLS, MN 56701

(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
01760	Continued From page 59 R2's Service Plan (Waiver)- Addendum to Contract dated September 25, 2024, indicated R2's services included medication administration five times per day. R2's prescriber orders dated September 12, 2024, included an order for levothyroxine (for thyroid) 100 micrograms (mcg)- take one table by mouth once daily before other medications. R2's Med (medication) Admin (administration) Summary dated, July 2025, indicated R2 received levothyroxine 100 mcg tablet by mouth once daily scheduled at 7:00 a.m., along with another medication scheduled at the same time. On July 15, 2025, at 7:03 a.m., the surveyor observed unlicensed personnel (ULP)-G administer scheduled morning medication administration for R2. The surveyor observed ULP-G administer R2's levothyroxine 100 mcg tablet along with all medications scheduled for 7:00 a.m. and 8:00 a.m. The surveyor did not observe R2 receive levothyroxine 100 mcg tablet before all other scheduled medications. ULP-G stated ULP-G had one hour before or after scheduled medication times to administered medications, which indicated all 7:00 a.m. and 8:00 a.m., medications were able to be administered together. The manufacturer instructions for levothyroxine dated August 2022, indicated to administer levothyroxine on an empty stomach, one-half to one hour before breakfast. R4 R4's diagnoses included diabetes, hypertension (HTN- high blood pressure), and depression.	01760		

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	30224	A. BUILDING: _____ B. WING _____	07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY ASSISTED LIVING	523 ARNOLD AVENUE SOUTH THIEF RIVER FALLS, MN 56701

(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
01760	Continued From page 60 R4's Service Plan (Waiver)- Addendum to Contract dated May 20, 2025, indicated R4's services included medication administration nine times per day. R4's prescriber orders dated November 24, 2024, included an order for Rybelsus (for diabetes) 3 mg tablet- take one tablet by mouth once daily on an am empty stomach 30 minutes before first food, beverage, or other medication with four ounces or less of plain water only. R4's Med (medication) Admin (administration) Summary dated July 2025, indicated R4 received Rybelsus 3 mg tablet by mouth once daily on an empty stomach 30 minutes before first food, beverage, or other medication with four ounces or less of plain water only scheduled at 11:30 a.m. R4's Med Admin Summary further indicated R4 was administered eight scheduled medications daily at 8:00 a.m. On July 16, 2025, at 1:35 p.m., clinical nurse supervisor (CNS)-B stated some levothyroxine instructions indicated to take an hour before other medications or food on an empty stomach and some levothyroxine instructions do not indicate to take an hour prior to other medications or food. CNS-B further stated ULPs were trained to follow the instructions on the resident's electronic medication administration records (EMAR). The licensee's Medication Reminders, Medication Set ups [sic] policy dated August 26, 2020, indicated the med aide (ULP) or nurse will use the MAR for documenting medications given from a dosage box and will refer to the medications profile listing the medication name, strength, description, amount to be given, and time of day to be given, as well as the purpose of the	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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VALLEY ASSISTED LIVING	523 ARNOLD AVENUE SOUTH THIEF RIVER FALLS, MN 56701

(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
01760	Continued From page 61 medication and any special instructions if applicable. The licensee's Medication and Treatment Orders Implementation policy dated August 26, 2020, indicated orders received will be implemented when in direct contact with the nurse. The policy further indicated, changes will be made to the MAR, by a nurse, if indicated. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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VALLEY ASSISTED LIVING	523 ARNOLD AVENUE SOUTH THIEF RIVER FALLS, MN 56701

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01770	Continued From page 62 The findings include: During the entrance conference on July 14, 2025, at 10:50 a.m., consultant (C)-C stated the licensee provided medication management to residents at the facility. R3's diagnoses included hypertension (HTN-high blood pressure), depression, and anxiety. R3's Service Plan (Waiver)- Addendum to Contract (service plan) dated August 6, 2024, indicated R3 received medication set up/storage one time per week. R3's prescriber orders dated August 21, 2024, included the following orders: -cerovite senior (supplement)- one tablet by mouth daily; -citalopram (for depression/anxiety) 10 milligrams (mg)- one tablet by mouth daily; -Eliquis (for deep vein thrombosis-DVT) 5 mg- take one tablet by mouth twice daily; -losartan (for HTN) 50 mg- take one tablet by mouth daily; -magnesium oxide (supplement) 400 mg- one tablet by mouth daily; -Mybetriq (for bladder) 25 mg- one tablet by mouth daily; -potassium (supplement) 10 milliequivalent (mEq)- one tablet by mouth daily; and -torsemide (for leg swelling) 20 mg- one tablet by mouth daily. On July 15, 2025, at 6:37 a.m., the surveyor reviewed the "Lane 2" medication cart with unlicensed personnel (ULP)-F. ULP-F stated the medication planner (a weekly box with separate compartments to place medications to be	01770		

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01770	Continued From page 63 administered at certain times of the day) was set up by clinical nurse supervisor (CNS)-B every week for R3. ULP-F further stated R3 was able to self-administer medications after CNS-B setup the medication planner. R3's Individualized Medication Management Plan dated May 14, 2025, indicated Nurse sets up medication box (planner) and R5 self-administered from the med (medication) box (planner). R3's Med (medication) Setup/ Review Summary-Month dated July 2025, was blank. R3's record lacked documentation for medication setup at the time of setup to include the dates of medication setup, name of the medication, quantity of dose, times to be administered, route of administration and name of person completing medication setup at the time of setup. On July 16, 2025, at 1:17 p.m., CNS-B stated CNS-B was not instructed correctly on how to document a medication set up. CNS-B further stated CNS-B documented on a nurse note of R3's medication setup, however, CNS-B stated the documentation did not meet the medication setup documentation requirement. CNS-B stated CNS-B was recently informed of the medication setup requirements. The licensee's Medication Reminders, Medication Set ups policy dated August 26, 2020, indicated a licensed nurse will set up medications in dosage boxes (medication planner) for the client (resident), usually on a weekly basis, and will make or direct changes between set ups when necessary. The policy did not address documentation of the medication set up.	01770		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY ASSISTED LIVING	523 ARNOLD AVENUE SOUTH THIEF RIVER FALLS, MN 56701

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01770	Continued From page 64 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's	01790		

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01790	Continued From page 65 medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) developed written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. In addition, the licensee failed to ensure one of one ULP (ULP-H) was trained and had demonstrated competency to prepare and give medications for residents having	01790		

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VALLEY ASSISTED LIVING	523 ARNOLD AVENUE SOUTH THIEF RIVER FALLS, MN 56701

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01790	Continued From page 66 unplanned time away. 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). The findings include: During the entrance conference on July 14, 2025, at 10:50 a.m., consultant (C)-C stated the licensee provided medication management to residents at the facility. UNPLANNED TIME AWAY POLICY AND PROCEDURE FOR ULP The licensee's Medication Administration-Outings policy dated August 26, 2020, indicated for unplanned resident time away the RN may delegate this task to the ULP for unplanned time away not to exceed five days (120 hours). The policy indicated any medications not taken will be documented in the client's (resident's) record by the nurse that received the form and medications. The licensee's policy lacked written procedures the RN developed to include the following: -the RN has trained the ULP and determined the ULP is competent to follow the procedures for giving medications to residents; -the RN has developed written procedures for the ULP, including any special instructions or procedures regarding controlled substances that are prescribed for the resident; -written information about the medications to be	01790		

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01790	Continued From page 67 provided; -the type of container to be used for the medications appropriate to the facility's medication system; and -how the ULP must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each medication returned. TRAINING AND COMPETENCY EVALUATIONS ULP-H was hired on April 30, 2025, to provide direct care services to residents at the assisted living with dementia care facility. On July 15, 2025, at 3:57 p.m., the surveyor observed ULP-H provide scheduled afternoon medication administration for R6. ULP-H's employee record lacked evidence to indicate ULP-H had been trained and had demonstrated competency to provide medications to residents for unplanned time away from the facility. On July 16, 2025, at 1:25 p.m., clinical nurse supervisor (CNS)-B stated CNS-B unplanned time away training and competency was completed with the initial medication administration training and was based on the facility's policy. The surveyor reviewed the Medication Administration- Outings policy dated August 26, 2020, with CNS-B. CNS-B stated the policy was supposed to indicate for ULPs to use envelopes with resident information listed on the outside, how to take each medication, and if the resident returned with medications not taken, the ULP would have returned the medications to CNS-B for destruction.	01790		

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01790	Continued From page 68 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for two of two residents (R2, R4) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on July 14, 2025, at 10:50 a.m., consultant (C)-C stated the licensee provided medication management to residents at the facility. R2 R2's diagnoses included chronic obstructive	01820		

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VALLEY ASSISTED LIVING	523 ARNOLD AVENUE SOUTH THIEF RIVER FALLS, MN 56701

(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
01820	Continued From page 69 pulmonary disease (COPD-difficult breathing), diabetes, and schizo-affective disorder. R2's Service Plan (Waiver)- Addendum to Contract dated September 25, 2024, indicated R2's services included medication administration five times per day. On July 15, 2025, at 7:03 a.m., the surveyor observed unlicensed personnel (ULP)-G administer scheduled morning medication administration for R2. R2's prescriber orders dated September 12, 2024, included the following medication: -vitamin D3 (supplement) 25 micrograms (mcg) by mouth daily -Miralax Powder (for constipation) 17 grams (g) by mouth every morning mixed with 8 ounces of water or liquid of choice -Seroquel (for schizophrenia) 200 milligrams (mg) by mouth every night R2's Med (medication) Admin (administration) Summary- Actual- Month dated July 2025, indicated R2's medication administration included the following medications: -Alendronate (for bone health) 35 mg was administered for a scheduled 6:00 a.m., medication on July 1, and 8, respectively; -Cholestyramine powder (for high cholesterol) 4 g was administered for a scheduled 8:00 a.m., medication on July 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, and 14, respectively; -nicotine (for smoking cessation) 21 mg/24-hour patch was offered to be administered for a scheduled 8:00 a.m., medication on July 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, and 14, respectively and was administered on July 13; -Asenapine (antipsychotic) 5 mg was	01820		

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	30224	A. BUILDING: _____ B. WING _____	07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY ASSISTED LIVING	523 ARNOLD AVENUE SOUTH THIEF RIVER FALLS, MN 56701

(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
01820	Continued From page 70 administered for a scheduled 8:00 p.m., medication on July 1, 2, 3, 5, and 9, respectively, and was offered to be administered on July 4, 6, 7, 8, 10, 11, 12, and 13, respectively; and -Vraylar (antipsychotic) 3 mg was administered for a scheduled 9:00 p.m., medication on July 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, and 13, respectively. R2's record lacked prescriber orders for the above noted medications. In addition, R2's record lacked prescriber orders to discontinue vitamin D3, Miralax powder, and Seroquel. On July 16, 2025, at 1:31 p.m., clinical nurse supervisor (CNS)-B stated CNS-B received separate orders for resident's medications if there was a change different than annual orders signed. CNS-B further stated CNS-B had "5,000 papers" to scan into resident records and would provide R2's orders noted above, however, the surveyor received no additional orders for R2. R4 R4's diagnoses included diabetes, hypertension (HTN- high blood pressure), and depression. R4's Service Plan (Waiver)- Addendum to Contract dated May 20, 2025, indicated R4's services included medication administration nine times per day. On July 15, 2025, at 11:00 a.m., the surveyor observed ULP-G administer scheduled morning medication administration for R4. R4's prescriber orders dated November 24, 2024, included the following medications: -Duloxetine (for depression) 30 mg by mouth daily	01820		

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01820	Continued From page 71 -Lantus Solostar (insulin) 100 units per milliliter (mL) inject 28 units under the skin one time per day R4 Med (medication) Admin (administration) Summary- Actual- Month dated July 2025, indicated R4's medication administration included the following medications: -Duloxetine 60 mg was administered as a scheduled medication at 8:00 a.m., on July 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, and 14, respectively; -Lantus Solostar 20 units were administered as a scheduled medication at 12:00 p.m., on July 1, 2, 3, 4, 5, 6, and 7, respectively; and -Lantus Solostar 10 units were administered as a scheduled medication at 12:00 p.m., on July 8, 9, 10, 11, 12, and 13, respectively. R4's record lacked prescriber orders to increase Duloxetine to 60 mg and decrease Lantus Solostar to 10 units per day. On July 16, 2025, at 1:45 p.m., CNS-B stated CNS-B had additional orders to provide for R4, however, the orders received from CNS-B lacked the above noted medications. The licensee's Medication and Treatment Orders policy dated August 26, 2020, indicated the RN (registered nurse) is responsible for assuring that current, authorized prescriber orders for medication or treatments administered by the staff are kept on file in the client's (resident's) medical chart. In addition, all orders for medications and treatments must be complete, dated and signed by the prescriber and must be current and consistent with the nursing assessment [sic].	01820		

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01820	Continued From page 72 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were stored according to manufacturer's instructions for one of one medication refrigerator. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on July 14, 2025, at 10:50 a.m., consultant (C)-C stated the licensee provided medication management to residents at the facility. On July 16, 2025, at 10:21 a.m., the surveyor reviewed the medication refrigerator locked in the	01880		

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01880	Continued From page 73 unlicensed personnel (ULP)/nurse office. ULP-H stated the current temperature of the refrigerator was 30 degrees Fahrenheit (F), and ULPs checked the refrigerator temperature one time per day. The refrigerator included the following medications: -two unopened Ozempic 4 milligrams (mg)/3 milliliters (mL) injections for R6 -14 unopened Lantus 100 units/mL insulin pens for R6 -15 unopened Toujeo Solostar 300 units/mL insulin pens for R5 The licensee's Chore History dated June 1, 2025, through July 16, 2025, indicated if the temperature was outside of the ranges of 36-46 degrees F, ensure that the fridge was properly closing and recheck the temperature within 30 minutes. Record the new temperature by selecting an "unscheduled chose" and recording was accordingly [sic]. If still outside of the range of 36-46 degrees F, contact administration, nursing, and maintenance through a notice in Rtasks (online documentation platform) messaging as well as call maintenance to address the concern. In the "unscheduled chore" note that you have sent a Rtask message and contacted maintenance. The following documentation was logged on the Chore History for the medication refrigerator being checked twice daily: -20 out of 92 opportunities the refrigerator temperature was documented as completed with no record of the refrigerator temperature -42 out of 72 opportunities the refrigerator temperature was documented as "okay", "k", "kk", "ok", or "done" -one (1) out of 30 opportunities the refrigerator temperature documented was not in range of 36-46 degrees F	01880		

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01880	Continued From page 74 -On July 16, 2025, at 9:47 a.m., ULP-H documented the refrigerator temperature was "okay" (the refrigerator temperature was 30 degrees F at 10:21 a.m.) On July 16, 2025, at 1:26 p.m., clinical nurse supervisor (CNS)-B stated the medication refrigerator temperature range was supposed to be kept between 36 to 46 degrees F. CNS-B further stated ULPs were supposed to contact the nurse on call if the refrigerator was out of temperature range, follow instructions from the nurse on call, and recheck the medication refrigerator temperature later for appropriate temperature range. The manufacturer's instructions for Ozempic dated October 2022, indicated before opening store the Ozempic pens in the refrigerator (36-46 degrees F). Do not allow the Ozempic to freeze. The manufacturer's instructions for Lantus insulin pens dated November 2018, indicated before opening store the insulin pens in the refrigerator (36-46 degrees F). Do not allow the Lantus to freeze. The manufacturer's instructions for Toujeo insulin pens dated February 2015, indicated before opening store the insulin pens in the refrigerator (36-46 degrees F). Do not allow the Toujeo to freeze. The licensee's Storage of Medications policy dated February 2022, indicated medications shall be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). No further information was provided.	01880		

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01880	Continued From page 75 TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01930 SS=F	144G.72 Subd. 2 Policies and procedures (a) An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines. (b) The written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting treatment or therapy activities, educating and communicating with residents about treatments or therapies they are receiving, monitoring and evaluating the treatment or therapy, and communicating with the prescriber. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures that were developed under the supervision and direction of a registered nurse (RN) consistent with current practice standards and guidelines. 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	01930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01930	Continued From page 76 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 14, 2025, at 11:00 a.m., consultant (C)-C stated the licensee provided treatment and therapy services to residents at the facility. On July 15, 2025, at 6:53 a.m., the surveyor observed unlicensed personnel (ULP)-G complete a blood glucose check for R4. The treatment and therapy policies provided did not include policies to address the following: -providing the treatment or therapy; -documenting the treatment or therapy; -monitoring and evaluating the treatment or therapy; and -communicating with the prescriber. On July 16, 2025, at 9:34 a.m., C-C stated C-C had provided the surveyor with all the licensee's documentation C-C was able to locate. On July 17, 2025, at 8:14 p.m., C-C emailed (electronic mail) C-C had provided all policies the surveyor requested, however, no additional treatment or therapy policies were provided to the surveyor. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01930		

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01940	Continued From page 77	01940		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management	01940		

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01940	Continued From page 78 plan to include all required content for one of two residents (R2) who had treatments or therapies managed by the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on July 15, 2025, at 11:00 a.m., consultant (C)-C stated the licensee provided treatment and therapy services to residents at the facility. R2's diagnoses included chronic obstructive pulmonary disease (COPD-difficult breathing), diabetes, and schizo-affective disorder. R2's Service Plan (Waiver)- Addendum to Contract dated September 25, 2024, indicated R2's services included oxygen management three times per day, and record oxygen saturation (level of oxygen in the blood) one time per month. R2's prescriber orders dated September 12, 2024, indicated oxygen management three times daily. R2's Assessment dated June 11, 2025, indicated R2 wore oxygen 2 liters (L) via nasal cannula (a flexible tube with two prongs, which delivers oxygen through the nose) at all times (continuously).	01940		

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01940	Continued From page 79 On July 15, 2025, at 7:03 a.m., the surveyor observed unlicensed personnel (ULP)-G administer scheduled morning medication administration for R2 and observed an oxygen concentrator located in R2's room, however, the oxygen concentrator was not in use. ULP-G stated R2 wore oxygen as needed. R2's record lacked a treatment plan including the following required information: -written statement of the treatment or therapy (oxygen) that would be provided; -documentation of specific resident instructions relating to the oxygen; -identification of treatment or therapy task that would be delegated to ULPs; -procedures for notifying a registered nurse (RN) when a problem arose with the oxygen; and -and resident-specific requirements relating to documentation of treatment or therapy received, verification that all treatment or therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On July 16, 2025, at 1:39 p.m., clinical nurse supervisor (CNS)-B stated R2's oxygen was not entered correctly as a treatment in R2's electronic medical record and CNS-B would have to double check on R2's oxygen treatment. CNS-B further stated each treatment for a resident required an individualized treatment management plan. A policy was requested, however, was not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

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01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions for one of two residents (R2) receiving treatment management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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).	01950		

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01950	Continued From page 81 The findings include: During the entrance conference on July 15, 2025, at 11:00 a.m., consultant (C)-C stated the licensee provided treatment and therapy services to residents at the facility. R2's diagnoses included chronic obstructive pulmonary disease (COPD-difficult breathing), diabetes, and schizo-affective disorder. R2's Service Plan (Waiver)- Addendum to Contract dated September 25, 2024, indicated R2's services included oxygen management three times per day, and record oxygen saturation (level of oxygen in the blood) one time per month. R2's prescriber orders dated September 12, 2024, indicated oxygen management three times daily. R2's Assessment dated June 11, 2025, indicated R2 wore oxygen 2 liters (L) via nasal cannula (a flexible tube with two prongs, which delivers oxygen through the nose) at all times (continuously). On July 15, 2025, at 7:03 a.m., the surveyor observed unlicensed personnel (ULP)-G administer scheduled morning medication administration for R2 and observed an oxygen concentrator located in R2's room, however, the oxygen concentrator was not in use. ULP-G stated R2 wore oxygen as needed. R2's Service Recap Summary- Actual- Month dated June 2025, and July 2025, respectively indicated oxygen management was documented AM (morning), PM (afternoon), and overnight.	01950		

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01950	Continued From page 82 R2's Treatment Recap Summary- Monthly dated July 2025, was blank and no treatments were listed. R2's record lacked specific instructions for when ULPs should notify the RN when a problem arises regarding oxygen management and communicated with the ULP about the individual needs of R2. On July 16, 2025, at 1:39 p.m., clinical nurse supervisor (CNS)-B stated R2's oxygen was not entered correctly as a treatment in R2's electronic medical record and CNS-B would have to double check on R2's oxygen treatment. CNS-B further stated documentation of oxygen management did not provide any instructions or details regarding R2's oxygen and was just a service ULPs signed off on three times per day. A policy was requested, however, was not provided. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01950		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must	01960		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY ASSISTED LIVING	523 ARNOLD AVENUE SOUTH THIEF RIVER FALLS, MN 56701

(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
01960	Continued From page 83 document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment services were documented as administered as prescribed, or to document the reason they were not provided for one of two residents (R2) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on July 15, 2025, at 11:00 a.m., consultant (C)-C stated the licensee provided treatment and therapy services to residents at the facility. R2's diagnoses included chronic obstructive pulmonary disease (COPD-difficult breathing), diabetes, and schizo-affective disorder. R2's Service Plan (Waiver)- Addendum to Contract dated September 25, 2024, indicated R2's services included oxygen management three times per day, and record oxygen saturation (level of oxygen in the blood) one time per month. R2's prescriber orders dated September 12,	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30224	A. BUILDING: _____ B. WING _____	07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY ASSISTED LIVING	523 ARNOLD AVENUE SOUTH THIEF RIVER FALLS, MN 56701

(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
01960	Continued From page 84 2024, indicated oxygen management three times daily. R2's Assessment dated June 11, 2025, indicated R2 wore oxygen 2 liters (L) via nasal cannula (a flexible tube with two prongs, which delivers oxygen through the nose) at all times (continuously). On July 15, 2025, at 7:03 a.m., the surveyor observed unlicensed personnel (ULP)-G administer scheduled morning medication administration for R2 and observed an oxygen concentrator located in R2's room, however, the oxygen concentrator was not in use. ULP-G stated R2 wore oxygen as needed. R2's Service Recap Summary- Actual- Month dated June 2025, and July 2025, respectively indicated oxygen management was documented AM (morning), PM (afternoon), and overnight. R2's Treatment Recap Summary- Monthly dated July 2025, was blank and no treatments were listed. R2's record lacked documentation of oxygen being applied, removed, oxygen flow rate, or route administered. On July 16, 2025, at 1:39 p.m., clinical nurse supervisor (CNS)-B stated R2's oxygen was not entered correctly as a treatment in R2's electronic medical record and CNS-B would have to double check on R2's oxygen treatment. CNS-B further stated documentation of oxygen management did not provide any instructions or details regarding R2's oxygen and was just a service ULPs signed off on three times per day.	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30224	A. BUILDING: _____ B. WING _____	07/16/2025

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VALLEY ASSISTED LIVING	523 ARNOLD AVENUE SOUTH THIEF RIVER FALLS, MN 56701

(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
01960	Continued From page 85 A policy was requested, however, was not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of two residents (R2) who received treatments managed by the provider. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include:	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30224	A. BUILDING: _____ B. WING _____	07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY ASSISTED LIVING	523 ARNOLD AVENUE SOUTH THIEF RIVER FALLS, MN 56701

(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
01970	Continued From page 86 During the entrance conference on July 15, 2025, at 11:00 a.m., consultant (C)-C stated the licensee provided treatment and therapy services to residents at the facility. R2's diagnoses included chronic obstructive pulmonary disease (COPD-difficult breathing), diabetes, and schizo-affective disorder. R2's Service Plan (Waiver)- Addendum to Contract dated September 25, 2024, indicated R2's services included oxygen management three times per day, and record oxygen saturation (level of oxygen in the blood) one time per month. R2's Assessment dated June 11, 2025, indicated R2 wore oxygen 2 liters (L) via nasal cannula (a flexible tube with two prongs, which delivers oxygen through the nose) at all times (continuously). R2's Service Recap Summary- Actual- Month dated June 2025, and July 2025, respectively indicated oxygen management was documented AM (morning), PM (afternoon), and overnight. R2's Treatment Recap Summary- Monthly dated July 2025, was blank and no treatments were listed. On July 15, 2025, at 7:03 a.m., the surveyor observed unlicensed personnel (ULP)-G administer scheduled morning medication administration for R2 and observed an oxygen concentrator located in R2's room, however, the oxygen concentrator was not in use. ULP-G stated R2 wore oxygen as needed. R2's prescriber orders dated September 12, 2024, indicated oxygen management three times	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30224	A. BUILDING: _____ B. WING _____	07/16/2025

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VALLEY ASSISTED LIVING	523 ARNOLD AVENUE SOUTH THIEF RIVER FALLS, MN 56701

(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
01970	Continued From page 87 daily. R2's record lacked a prescriber order for oxygen to include the frequency, duration, and other information needed to administer the oxygen. On July 16, 2025, at 1:40 p.m., clinical nurse supervisor (CNS)-B stated R2's record lacked a specific oxygen order. CNS-B further stated CNS-B was aware treatments required a signed prescriber order. The licensee's Medication and Treatment Orders policy dated August 26, 2020, indicated a RN (registered nurse), LPN (licensed practical nurse), therapist or person qualified to receive orders will obtain all medications and treatment orders either in writing, verbally, or electronically by an authorized prescriber per the Comprehensive home care regulations [sic]. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care must meet the requirements of section 144G.45 and the following additional requirements: (1) an assessment of safety risks must be performed on and around the property. The safety risks identified by the facility on the assessment must be mitigated to protect the residents from harm. The mitigation efforts must be documented in the facility's records; and (2) the facility shall be protected throughout by an	02040		

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	30224	A. BUILDING: _____ B. WING _____	07/16/2025

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VALLEY ASSISTED LIVING	523 ARNOLD AVENUE SOUTH THIEF RIVER FALLS, MN 56701

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02040	Continued From page 88 approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on July 15, 2025, at 2:45 p.m. with consultant (C) -C on the hazard vulnerability assessment for the physical environment of the facility. Record review indicated that the licensee had not performed a hazard vulnerability assessment with risk and mitigation factors on and around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

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02320	Continued From page 89	02320		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the steps of the medication administration process was followed for one of three employees (unlicensed personnel (ULP)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on July 14, 2025, at 10:50 a.m., consultant (C)-C stated the licensee provided medication management to residents at the facility. On July 15, 2025, at 5:59 a.m., the surveyor observed ULP-F provide scheduled medication administration for R2. ULP-F removed R2's alendronate 35 milligrams (mg) bubble pack	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02320	Continued From page 90 (prepackaged medication set up per pharmacy) from the medication cart, punched out one tablet of alendronate from the bubble pack into a paper cup, and placed the bubble pack back into the medication cart. ULP-F stated the licensee's internet and online documentation system was down after 11:00 p.m. last night (July 14, 2025), however, ULP-F stated ULP-F was aware R2 was administered alendronate 35 mg every Tuesday morning and referred the surveyor to the label on the bubble pack. ULP-F proceeded to R2's room and administered alendronate 35 mg to R2. ULP-F stated ULP-F would document alendronate 35 mg on the next scheduled shift ULP-F was scheduled to work and would inform the daytime ULP alendronate was administered to R2. ULP-F further stated ULP-F did not know the licensee's back up plan to administer medications if the online documentation system was down. On July 15, 2025, at 6:41 a.m., ULP-G arrived at the facility and accessed the licensee's online documentation system via ULP-G's smart phone. ULP-F stated ULP-F did not have a smart phone and was not able to access the licensee's online documentation system. On July 15, 2025, at 8:25 a.m., C-C stated C-C was not sure if the licensee had a back up plan if the internet and online documentation system was down. On July 15, 2025, at 12:54 p.m., clinical nurse supervisor (CNS)-B stated ULPs were not supposed to administer medications unless ULPs had access to the online documentation system or a printed medication administration record (MAR) for the resident. CNS-B further stated ULP-F was supposed to contact the registered nurse (RN) on call for guidance if ULP-F was	02320		

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02320	Continued From page 91 unable to access the online documentation system and the RN would have provided a printed MAR. CNS-B further stated ULPs were trained on the five rights of medication administration, including checking the medication label with the resident's MAR, to be completed three times, and once ULPs administered the medication documentation was completed within 10 minutes. The licensee's Medication Management Services-Med (medication) Aide policy dated August 26, 2020, indicated a RN (registered nurse) must instruct the med (medication) aide (ULP) on the following medications administration tasks and deem the medication aide competent before delegating the medication administration task to the med aide: -the complete procedure of checking a client's (resident's) MAR; -the procedure related to the type of medication administration; -the preparation of medication for administration; -the reminder to self-administer medications; and -the documentation after assistance with medication reminder or medication administration, of the date, time, dosage, and method of administration of all medications, or the reason for not assisting with medication administration as ordered, and the initials of the nurse or authorized person who assisted or administered and observed the same [sic]. The licensee's Medication Reminders, Medication Setups policy dated August 26, 2020, indicated documentation of a medication reminder, medication assistance or medication administration will be completed immediately after that task (medication administration) has been performed.	02320		

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02320	Continued From page 92 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

Bemidji District Office
Minnesota Department of Health
707 5th St NW, Suite A
Bemidji, MN 56601
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Valley Assisted Living
523 Arnold Ave S
Thief River Falls, MN 56701
Pennington County
Parcel:

Phone:

License Info

License: HFID 30224

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

Inspection Info

Report Number: F1040251025
Inspection Type: Full - Single
Date: 7/14/2025 Time: 1:09:35 PM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 1
Total Priority 2 Orders: 2
Total Priority 3 Orders: 1
Delivery:

New Order: 2-100 Supervision
2-101.11 *Priority Level: Priority 2 CFP#: 1*
MN Rule 4626.0025 Designate a person in charge and ensure that the person in charge is present in the establishment during all hours of operation.
COMMENT: AT TIME OF INSPECTION NO CFPM AVAILABLE AS KITCHEN IS NOT IN OPERATION, EMPLOY BEFORE REOPENING
Comply By: Comply Before Opening Originally Issued On: 7/14/2025

! **New Order: 3-300B Protection from Contamination: cross-contamination, eggs**
3-302.11A(1) *Priority Level: Priority 1 CFP#: 15*
MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.
COMMENT: OBSERVED RAW EGGS STORED ABOVE READY TO EAT PASTA IN COMMERCIAL REFRIGERATOR.
Comply By: 7/14/2025 Originally Issued On: 7/14/2025

New Order: 4-200 Equipment Design and Construction
4-201.11AMN *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.
COMMENT: AT TIME OF INSPECTION MILK FOR RESIDENTS STORED IN A DOMESTIC WHIRLPOOL COOLER
Comply By: 7/14/2025 Originally Issued On: 7/14/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.12B *Priority Level: Priority 2 CFP#: 36*
MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.
COMMENT: AT TIME OF INSPECTION NO THIN TIP THERMOMETER WAS ABLE TO BE LOCATED.
Comply By: 7/14/2025 Originally Issued On: 7/14/2025

Food & Beverage General Comment

AT TIME OF INSPECTION KITCHEN NOT OPERATIONAL DUE TO WATER PIPE IN DINING HALL HAVING JUST FINISHED BEING REPLACED, WALK-IN COOLERS AND FREEZERS NOT IN USE. FOOD IS BEING CATERED FROM GREEN LEAF TO VALLEY ASSISTED LIVING, AND DISTRIBUTED PACKAGED INDIVIDUAL MEALS IS BEING TRANSPORTED. COULD NOT INSPECT DISH MACHINE DUE TO THIS. TEST STRIPS FOR CHLORINE AND QUATERNARY AMMONIA WERE AVAILABLE.

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 Bemidji District Office inspection report number F1040251025 from 7/14/2025

Establishment Representative

Vania Jeh,
Public Health Sanitarian 1
218-308-2124
vania.jeh@state.mn.us

Bemidji District Office
Minnesota Department of Health
707 5th St NW, Suite A
Bemidji, MN 56601

Temperature Observations/Recordings

Establishment Info

Valley Assisted Living
Thief River Falls
County/Group: Pennington County

Inspection Info

Report Number: F1040251025
Inspection Type: Full
Date: 7/14/2025
Time: 1:09:35 PM

Equipment Temperature: **Product/Item/Unit:** COMMERICAL COOLER, PASTA**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** DOMESTIC REFRIGERATOR, MILK**; Temperature Process:** Cold-Holding
Location: Cooler at 41 Degrees F.
Comment:
Violation Issued?: No