Electronically Delivered

April 9, 2026

Licensee
Valley Terrace of Owatonna
1212 West Frontage Road
Owatonna, MN 55060

RE: Project Number(s) SL25302017

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 20, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

pursuant to this survey:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $1,000.00
St - 0 - 0800 - 144g.45 Subd. 2 (a) (4) - Fire Protection And Physical Environment - $1,000.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $1,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

To submit a hearing request, please visit:

https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25302	A. BUILDING: _____ B. WING _____	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY TERRACE OF OWATONNA	1212 WEST FRONTAGE ROAD OWATONNA, MN 55060

(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: SL25302017-0 On March 17, 2026, through March 20, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 51 residents; 51 receiving services under the Assisted Living Facility license. 1290: An immediate correction order was issued on March 19, 2026, at a level 3/Widespread (I). The licensee took immediate action; however, the scope and level remain at I. 2310: An immediate correction order was issued on March 20, 2026, at a level 4/Widespread (L). The licensee took immediate action; however, the scope and level remain at L.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements	0 470		

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0 470	Continued From page 1 (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 staffing plan was reviewed twice per year. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 470		

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0 470	Continued From page 2 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: The licensee held an Assisted Living license, was licensed for a capacity of 86 residents, and had a current census of 51 residents. During the entrance conference on March 17, 2026, at 10:13 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated four unlicensed personnel (ULP) were staffed on the day and evening shifts and two ULP for the night shift. The licensee's Staffing Management Plan included "Plan Reviewed Dates" of September 27, 2024, and September 19, 2025. There was no evidence that the staffing plan had been reviewed twice per year as required. On March 17, 2026, at 4:20 p.m. LALD-A stated the staffing plan had only been reviewed once yearly and indicated the twice per year review had been "missed". The licensee's Staffing Management Plan dated September 19, 2025, noted the staffing plan was intended to be a living document, reviewed at least semi-annually, and updated as needed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		

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0 480	Continued From page 3	0 480		
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 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;	0 480		

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0 480	Continued From page 4 (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 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 March 18, 2026, for the specific Minnesota Food Code violations. The Inspection	0 480		

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0 480	Continued From page 5 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		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place, the email contact information for the individual responsible for handling resident grievances. This had the potential to affect the licensee's current 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	0 550		

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0 550	Continued From page 6 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: On March 17, 2026, at 11:15 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A and observed the posted grievance procedure on a wall near the dining room. The procedure included the title and telephone number for the individual responsible for handling grievances, but it lacked the individual's name and email contact information. LALD-A stated the form lacked the name and email contact information and was not aware it was required on the form. The licensee's 2.10 Complaint/Grievance Posting policy dated July 1, 2022, noted the licensee would post, in a conspicuous place, information about our complaint/grievance procedure, and the name, telephone number, and email contact information for the individual(s) who are responsible for handling resident complaint/grievances. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 775 SS=I	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the	0 775		

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0 775	Continued From page 7 State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation harmed a resident's health or safety, not including serious injury or death, or a violation that was likely to lead to serious injury or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 3/17/2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) days.	0 775		
0 800 SS=I	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the	0 800		

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0 800	Continued From page 8 residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 3/17/2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) 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	0 810		

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0 810	Continued From page 9 plans shall include but are not limited to: (1) location and number of resident sleeping 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 ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.	0 810		

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0 810	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, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 3/17/2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	0 810		
0 830 SS=D	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, interview, and record review, the licensee failed to follow applicable	0 830		

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0 830	Continued From page 11 state and local laws, regulations, standards, ordinances, and codes related to smoking for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On March 17, 2026, at 12:11 p.m., the surveyor noted smell of cigarette smoke in west first floor hallway. On March 17, 2026, at 1:30 p.m., the engineer surveyor noticed a strong smell of cigarette smoke in the west hallway. Engineer surveyor entered R2's room with maintenance supervisor (MS)-C and observed R2 wheeling themselves backwards from the patio door while wearing a nasal cannula that was connected to an oxygen concentrator running in his room. R2 stated he had just extinguished a cigarette in a metal can outside in the snow and admitted to smoking in his room while wearing his oxygen. R2's diagnoses included bipolar disorder (mental health condition that causes extreme mood swings), history of chronic alcohol use, chronic obstructive pulmonary disease (progressive lung disease that makes it difficult to breathe) and nicotine dependence. R2's Service Plan (Waiver) - Addendum to	0 830		

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	25302	A. BUILDING: _____ B. WING _____	03/20/2026

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0 830	Continued From page 12 Contract dated March 4, 2026, indicated R2 required assistance with bathing, dressing, grooming, toileting, behavior management for non-compliance, medication administration, and oxygen assistance. R2's 90-day assessment dated February 17, 2026, indicated R2 demonstrated ability to safely smoke from lighting to extinguishing the cigarette. However, the assessment also identified R2 had been found smoking in his room with the oxygen on. Staff continue to monitor closely and report to supervisor if he does not redirect. R2's Behavior Recap dated January 1, 2026, through March 20, 2026, included 17 documented smoking redirections. In addition, the following was noted: -January 12, 2026, 10:30 p.m., resident was caught smoking with his oxygen on sitting in his room with his patio door open. Resident verbally redirected not to smoke with oxygen on or in his room. During a second check resident was again smoking with oxygen on and reminded of the dangers of smoking with oxygen tanks near him and while wearing oxygen. -March 14, 2026, at 7:00 a.m., resident was caught smoking with oxygen on, staff gave him a reminder that oxygen needs to be turned off and he needs to be outside to smoke. -March 14, 2026, at 12:00 p.m., resident was found smoking in his room with oxygen on and sliding door open, reminders to smoke outside given. -March 15, 2026, at 7:20 a.m., resident was smoking with door to the outside cracked but with his oxygen on. He was reminded not to do that. -March 16, 2026, at 10:30 p.m., resident was caught smoking with oxygen on sitting by his sliding door with his nasal cannula on smoking a	0 830		

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0 830	Continued From page 13 cigarette. Resident was reminded to go outside to prevent a fire or explosion. On March 17, 2026, at 3:06 p.m., clinical nurse supervisor (CNS)-B stated R2 was able to smoke independently but was unsafe, because he did not always take his oxygen off or go outside. CNS-B stated there had been meetings with R2, R2's guardian, and the regional Ombudsman to mitigate. On March 19, 2026, at 8:52 a.m., CNS-B stated the licensee had implemented extra safety checks to ensure he was not smoking in his room. CNS-B stated despite this, R2 had continued to smoke in his room. On March 20, 2026, at 9:27 a.m., licensed assisted living director (LALD)-A stated it was "no secret" that R2 smoked in his room. LALD-A stated she was aware something should have been done to mitigate R2's smoking in his room as no one was allowed to smoke within the facility. The Minnesota Department of Health's Minnesota Clean Indoor Air Act (MCIAA) amendment effective on August 1, 2019, noted smoking was prohibited indoors of all public places to include health care facilities and clinics. MCIAA defined "Indoor Area" to be "a space between a floor and a ceiling that is at least half enclosed by walls, doorways or windows (open or closed) around the perimeter. State statute 144.414 Prohibitions; Subdivision 3 Health care facilities and clinics. (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility,	0 830		

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0 830	Continued From page 14 except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 830		
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 interview and record review, the licensee failed to ensure a background study was current and eligible on NETStudy 2.0 (web-based system for submitting background study requests to the Department of Human Services (DHS))	01290		

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01290	Continued From page 15 with the assisted living license for three of 38 employees (clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP)-D, and dietary aide (DA)-E). This had the potential to affect all residents residing in the facility. This resulted in an immediate correction order issued on March 19, 2026. 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: CNS-B CNS-B was hired on July 10, 2024, and provided unsupervised direct care for the licensee's residents. The licensee's NETStudy 2.0 roster did not include CNS-B. There was no current background study in NETStudy 2.0 for CNS-B. ULP-D ULP-D was hired on November 9, 2021, and provided unsupervised direct care services for the licensee's residents. The licensee's NETStudy 2.0 roster identified ULP-D and indicated "Eligible - COVID-19 Study - Expired," with an expiration date of December 31, 2022.	01290		

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01290	Continued From page 16 There was no current background study in NETStudy 2.0 for ULP-D DA-E DA-E was hired on August 15, 2023, and had unsupervised contact with the licensee's residents. The licensee's NETStudy 2.0 roster did not include DA-E. There was no current background study in NETStudy 2.0 for DA-E On March 19, 2026, at 12:12 p.m., licensed assisted living director (LALD)-A stated the above- named employees were lacking a background study clearance and indicated she was not sure how this happened. LALD-A further stated all employees had been working unsupervised with the licensee's residents. In addition, LALD-A stated all employees were required to have a cleared background check before performing duties at the facility. The licensee's 4.02 Background Studies policy dated July 1, 2022, indicated the licensee will conduct a Minnesota Department of Human Services Background Study on all employees, volunteers, and contractors. No employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study have been received. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		

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01290	Continued From page 17 On March 19, 2026, the licensee took immediate action; however, the scope and level remains at l.	01290		
01500 SS=D	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 support services provided by the staff person.	01500		

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01500	Continued From page 18 (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 annual training included all required topics for each 12 months of employment for one of two employees (unlicensed personnel (ULP)-G). 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).	01500		

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01500	Continued From page 19 The findings include: ULP-G began providing direct care services for the licensee on February 21, 2022. ULP-G's employee record lacked evidence of the following required annual training: - Review of provider's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. On March 20, 2026, at 3:00 p.m., licensed assisted living director (LALD)-A stated ULP-G's employee filed lacked the required annual training as noted above. LALD-A stated there is a sheet the employee signs after the policies are reviewed but was unable to find ULP-G's for 2025. The licensee's 5.06 Annual Required Staff Training policy dated July 1, 2022, identified the following training elements MUST be included every 12 months to all staff who perform direct care services: 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date	01640		

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01640	Continued From page 20 that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included a signature or other authentication by the resident and the licensee to document agreement on the services to be provided for one of three residents (R2). 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).	01640		

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01640	Continued From page 21 The findings include: R2's diagnoses included bipolar disorder (mental health condition that causes extreme mood swings), history of chronic alcohol use, chronic obstructive pulmonary disease (progressive lung disease that makes it difficult to breathe) and nicotine dependence. R2's Service Plan (Waiver) - Addendum to Contract dated March 4, 2026, indicated R2 required assistance with bathing, dressing, grooming, toileting, behavior management for non-compliance, medication administration, and oxygen assistance. Although the service agreement was signed by the resident's representative, it lacked a signature or other authentication by the facility documenting agreement on the services to be provided. On March 20, 2026, at 8:10 a.m., clinical nurse supervisor (CNS)-B stated R2's service plan was lacking the licensee's signature and indicated it should be signed by both the resident/resident's responsible party and the licensee. The licensee's 6.08 Service Plan policy dated revised July 1, 2022, noted a service plan and any revisions would include a signature or other authentication by the assisted living and by the resident or the resident's representative, documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		

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01700	Continued From page 22	01700		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one resident (R2) who self-administered medications was assessed for self-administration of medications.	01700		

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01700	Continued From page 23 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 March 17, 2026, at 10:13 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. R2's diagnoses included bipolar disorder (mental health condition that causes extreme mood swings), history of chronic alcohol use, chronic obstructive pulmonary disease (progressive lung disease that makes it difficult to breathe) and nicotine dependence. R2's Service Plan (Waiver) - Addendum to Contract dated March 4, 2026, indicated R2 required assistance with medication administration. On March 18, 2026, at 1:50 p.m., the surveyor interviewed R2 in his room and observed a Ventolin inhaler (fast-acting inhaler to open airways) on R2's bedside table. R2 stated he utilized the inhaler independently "when he needed it to catch his breath" and indicated he had last used it a few days ago. R2's 90-day assessment dated February 17, 2026, included an assessment of R2's medications and an individualized medication	01700		

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01700	Continued From page 24 management plan. The assessment indicated R2 required full medication management by staff. R2 lacked an assessment for self-administration of medication. On March 20, 2026, at 8:05 a.m., clinical nurse supervisor (CNS)-B stated R2's assessment did not identify if he could independently administer the inhaled medication. CNS-B indicated she was not aware R2 was self-administering or had an inhaler in his room. CNS-B further stated an assessment would need to be completed to determine R2's ability to safely self-administer the medication. The licensee's 7.01 Medication Management-Assessment, Monitoring & Reassessment policy dated July 1, 2022, indicated a registered nurse would conduct an assessment to determine what and how medication management services would be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for	01730		

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01730	Continued From page 25 each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25302	A. BUILDING: _____ B. WING _____	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY TERRACE OF OWATONNA	1212 WEST FRONTAGE ROAD OWATONNA, MN 55060

(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
01730	Continued From page 26 the required content for one of three residents (R2). 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 March 17, 2026, at 10:13 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to the residents at the facility. R2's diagnoses included bipolar disorder (mental health condition that causes extreme mood swings), history of chronic alcohol use, chronic obstructive pulmonary disease (progressive lung disease that makes it difficult to breathe) and nicotine dependence. R2's Service Plan (Waiver) - Addendum to Contract dated March 4, 2026, indicated R2 required assistance with medication administration. R2's prescriber orders dated May 16, 2025, included an order for Ventolin inhaler one puff by mouth every six hours as needed for wheezing. On March 18, 2026, at 1:50 p.m., the surveyor interviewed R2 in his room and observed a Ventolin inhaler (fast-acting inhaler to open	01730		

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01730	Continued From page 27 airways) on R2's bedside table. R2 stated he utilized the inhaler independently "when he needed it to catch his breath" and indicated he had last used it a few days ago. R2's 90-day assessment dated February 17, 2026, included an assessment of R2's medications and an individualized medication management plan. The assessment indicated R2 required full medication management by staff. In addition, the assessment identified medications were stored in a locked medication cart. R2 lacked an assessment for self-administration of medication. On March 20, 2026, at 8:05 a.m., clinical nurse supervisor (CNS)-B stated she had not done a self-administration assessment or updated R2's medication plan to reflect self-administration or the storage of R2's Ventolin inhaler. CNS-B further stated R2's current medication management plan was inaccurate. The licensee's 7.03 Medication Management Individualized Plan policy dated July 1, 2022, noted the licensee would develop and maintain a current individualized medication management record for each resident based on the resident's assessment. The medication management record will be current and updated when there are any changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01890 SS=D	144G.71 Subd. 20 Prescription drugs	01890		

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01890	Continued From page 28 A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the prescription label matched the order for one of six residents (R3) 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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnoses included bipolar disorder (mental health condition that causes extreme mood swings), and dementia (problems with memory, thinking, and ability to perform everyday activities). R3's Service Plan (Waiver) - Addendum to Contract dated effective March 6, 2026, included medication administration. R3's prescriber orders dated June 25, 2025, included:	01890		

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01890	Continued From page 29 - ammonium lactate 12% cream (exfoliates dead skin cells) apply topically three times daily to heels and once daily as needed (PRN) for heel cracks. R3's medication administration Summary dated March 2026, included the medication as ordered above. On March 18, 2026, at 10:29 a.m., the surveyor observed unlicensed personnel (ULP)-J administer ammonium lactate 12% cream to R3's heels. The ammonium lactate 12% cream had a label that directed to administer three times daily PRN. When interviewed at this time, ULP-J stated the label for R3's ammonium lactate 12% cream did not match the MAR, but she would follow the MAR instead of the label. On March 20, 2026, at 8:00 a.m., clinical nurse supervisor (CNS)-B stated the prescription label should match the current prescriber orders and MAR. CNS-B stated staff should have alerted her of the discrepancy, and there should have been a "direction change" sticker applied to the prescription label. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02310 SS=L	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care	02310		

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02310	Continued From page 30 standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure appropriate care and services were provided based on the resident's needs and according to an up-to-date assessment and service plan subject to accepted health care standards when smoking assessment safety interventions were not implemented for one of one resident (R2). This had the potential to affect all residents and staff and resulted in an immediate correction order on March 20, 2026. This practice resulted in a level four violation (a violation that harmed a resident's health or safety, not including serious injury or death, or a violation that was likely to lead to serious injury 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 March 17, 2026, at 1:30 p.m., the engineer surveyor noticed a strong smell of cigarette smoke in the west hallway. Engineer surveyor entered R2's room with maintenance supervisor (MS)-C and observed R2 wheeling themselves backwards from the patio door while wearing a nasal cannula that was connected to an oxygen concentrator running in his room. R2 stated he had just extinguished a cigarette in a metal can outside in the snow, and admitted to smoking while wearing his oxygen. R2's diagnoses included bipolar disorder (mental health condition that causes extreme mood	02310		

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02310	Continued From page 31 swings), history of chronic alcohol use, chronic obstructive pulmonary disease (progressive lung disease that makes it difficult to breathe) and nicotine dependence. An Incident/Injury report dated November 12, 2025, noted R2 had burnt his nose while smoking and using his oxygen. Resident was evaluated the the emergency department due to pain and blisters forming in his nose. The actions taken to prevent recurrence included: "he knows not to have oxygen on and should be smoking outside. It was noted after incident that he was also drinking. This may have been a contributor. Drinking is hard to stop as he pays friends to bring it in for him." The incident lacked interventions to prevent a reoccurrence. R2's 90-day assessment dated February 17, 2026, indicated R2 demonstrated ability to safely smoke from lighting to extinguishing the cigarette. However, the assessment identified R2 had been found smoking in his room with the oxygen on. Staff continue to monitor closely and report to supervisor if he does not redirect. R2's Service Plan (Waiver) - Addendum to Contract dated March 4, 2026, indicated R2 required assistance with bathing, dressing, grooming, toileting, behavior management for non-compliance, medication administration, and oxygen assistance. R2's individual abuse prevention plan (IAPP) dated March 10, 2026, indicated R2 smoked and had been found smoking in his room with oxygen on. This has been addressed with R2 and staff continue to monitor closely. The assessment did not include interventions regarding safe smoking.	02310		

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02310	Continued From page 32 R2's undated, Behavior Plan with a print date of March 20, 2026, included an identified behavior of smoking while having his oxygen on. Interventions identified: - remind resident to turn oxygen off prior to smoking; - turn off the oxygen if he is unwilling to while he is smoking, and put back on when he is done smoking; - notify nurse if he is refusing to allow staff to turn off oxygen and document occurrences, interventions, and success/failure of the intervention. R2's Behavior Recap dated January 1, 2026 through March 20, 2026, included 17 documented smoking redirections. In addition, the following was noted: -January 12, 2026, 10:30 p.m., resident was caught smoking with his oxygen on sitting in his room with his patio door open. Resident verbally redirected not to smoke with oxygen on or in his room. During a second check resident was again smoking with oxygen on and reminded of the dangers of smoking with oxygen tanks near him and while wearing oxygen. -March 14, 2026, at 7:00 a.m., resident was caught smoking with oxygen on, staff gave him a reminder that oxygen needs to be turned off and he needs to be outside to smoke. -March 14, 2026, at 12:00 p.m., resident was found smoking in his room with oxygen on and sliding door open, reminders to smoke outside given. -March 15, 2026, at 7:20 a.m., resident was smoking with door to the outside cracked but with his oxygen on. He was reminded not to do that. -March 16, 2026, at 10:30 p.m., resident was caught smoking with oxygen on sitting by his sliding door with his nasal canula on smoking a	02310		

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02310	Continued From page 33 cigarette. Resident was reminded to go outside to prevent a fire or explosion. On March 17, 2026, at 3:06 p.m., clinical nurse supervisor (CNS)-B stated R2 was able to smoke independently but was unsafe, because he did not always take his oxygen off or go outside. CNS-B stated there had been meetings with R2, R2's guardian, and the regional Ombudsman to mitigate. On March 19, 2026, at 8:52 a.m., CNS-B stated the licensee had implemented extra safety checks to ensure he was not smoking with his oxygen on and when staff report he is smoking, a lease violation is given. CNS-B stated despite this, R2 has continued to smoke in his room and not remove his oxygen. On March 20, 2026, at 9:27 a.m., licensed assisted living director (LALD)-A stated it was "no secret" that R2 smoked in his room with oxygen on. LALD-A stated she was aware something should have been done to mitigate R2's smoking in his room with oxygen on as this was causing other residents and staff to be at risk. Minnesota Department of Health Smoking Regulations dated July 2016, noted smoking must be prohibited in any location where oxygen, flammable or combustible liquids or gases, or combustible materials are stored or used. - No one using oxygen should be allowed to smoke. National Fire Protection Association (NFPA) requires that smoking materials be removed from patients receiving respiratory therapy. - Smokers must remain at least 5 (five) feet away from oxygen in use.	02310		

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02310	Continued From page 34 The licensee did not have a smoking policy. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On March 20, 2026, the licensee took immediate action; however, the scope and level remains at L.	02310		

Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

VALLEY TERRACE OF OWATONNA
1212 WEST FRONTAGE ROAD
Owatonna, MN 55060
Steele County
Parcel:

Phone:
tiffany@thevalleyterrace.com

License Info

License: HFID 25302

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

Inspection Info

Report Number: F8044261084
Inspection Type: Full - Single
Date: 3/18/2026 Time: 8:17:35 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 2
Total Priority 2 Orders: 1
Total Priority 3 Orders: 5
Delivery: Emailed

New Order: 2-100 Supervision
2-102.12AMN *Priority Level: Priority 3 CFP#: 2*
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
COMMENT: No full-time CFPM on staff.
Comply By: 5/18/2026 Originally Issued On: 3/18/2026

! **New Order: 3-500B Microbial Control: hot and cold holding**
3-501.16A2 *Priority Level: Priority 1 CFP#: 22*
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
COMMENT: Originally issued on 4/24/23.
3/18/26: Reissued. Milk stored on ice, rather than in mechanical refrigeration during serving period.
Comply By: 3/18/2026 Originally Issued On: 3/18/2026

New Order: 5-200C Plumbing: Maintenance, fixture location
5-205.13 *Priority Level: Priority 2 CFP#: 51*
MN Rule 4626.1120 Inspect, test and maintain water treatment and backflow prevention devices according to the manufacturer's instructions and as necessary to prevent device failure. The person in charge must maintain records of inspection and service of water treatment and backflow prevention devices.
COMMENT: Ice machine filter not dated with install date. These filters should be replaced at least annually or according to manufacturer's instructions.
Comply By: 3/18/2026 Originally Issued On: 3/18/2026

! **New Order: 5-400 Sewage**
5-402.11A *Priority Level: Priority 1 CFP#: 52*
MN Rule 4626.1190A Provide an indirect connection between the sewage system and any drain originating from equipment in which food, portable equipment or utensils are placed, such as manufacturing and retail display equipment, portable equipment, ice bins, salad bars, cocktail stations and dipper wells.
COMMENT: No air gap with floor drain for ice machine drain hose.
Comply By: 3/31/2026 Originally Issued On: 3/18/2026

New Order: 6-200 Physical Facility Design and Construction
6-201.11A *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1335A Design, construct, and install floors, floor coverings, walls, wall coverings, and ceilings to be smooth and easily cleanable.
COMMENT: Unfinished wall patch above serving line.
Comply By: 5/18/2026 Originally Issued On: 3/18/2026

New Order: 6-200 Physical Facility Design and Construction
6-201.13A *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1345A Properly cove and seal the wall/floor junctures to no larger than 1/32 inch (1 millimeter).
COMMENT: Originally issued on 4/24/23.
3/18/26: Reissued. Coved base missing from floor/wall juncture beneath prep sink.
Comply By: 3/18/2026 Originally Issued On: 3/18/2026

New Order: 6-300 Physical Facility Numbers and Capacities
6-304.11B *Priority Level: Priority 3 CFP#: 56*
MN Rule 4626.1475B Design, install and operate all ventilation systems, furnaces, gas or oil-fired heaters, and water heaters according to Minnesota Rules chapters 1305, 1346, and 7511.
COMMENT: Fire suppression tag dated April 2023, and should be serviced at least annually.
Comply By: 4/18/2026 Originally Issued On: 3/18/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.11 *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1515 Maintain the physical facilities in good repair.
COMMENT: Originally issued on 4/24/23.
3/18/26: Reissued. Peeling paint from block wall in men's restroom. Stained ceiling tiles in kitchen.
Comply By: 3/18/2026 Originally Issued On: 3/18/2026

Food & Beverage General Comment

HRD inspection conducted with Susan Kalis. Inspection report reviewed on site with Rachel.

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 Rochester District Office inspection report number F8044261084 from 3/18/2026

Rachel Luna

Michael DeMars, RS
Public Health Sanitarian 3
michael.demars@state.mn.us

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL25302017-0	**Date:** 3/17/2026
Facility Name: VALLEY TERRACE OF OWATONNA	
Facility Address: 1212 WEST FRONTAGE RD, OWATONNA MN 55060	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 3; Widespread **TIME PERIOD OF CORRECTION:** Two (2) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. Smoking shall be prohibited where conditions are such as to make smoking a hazard, and in spaces where flammable or combustible materials are stored or handled. [Minn. Stat. 144G.45 subd. 2; MSFC 310.2]

   Comments: Resident in room 158 was smoking cigarettes in the room that also had 24+ compressed oxygen cylinder bottles, while using an oxygen concentrator. Smoking inside a unit residential room with stored pressured oxygen cylinders present creates a dangerous environment for themselves, fellow residents, staff members and others in the facility.

3. Medical gases stored and transferred in health-care-related facilities shall be in accordance with Chapter 53 and NFPA 99.

   Comments: Resident room 158 had over 24 compressed oxygen cylinders bottles stored in the studio apartment, this exceeded the maximum allowable storage quantities.

4. The means of egress shall be maintained free of obstructions or impediments to full instant use in case of fire or other emergency. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.2]

   Comments: The Southside stairwell exit door was blocked by snow and unable to open.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 3; Widespread **TIME PERIOD OF CORRECTION:** Two (2) days

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

   Comments: The North and West side roofs showed evidence of leaking and creating water and mold issues in the unoccupied resident rooms below. West side rooms had mold mitigation efforts from a licensed contractor despite the roof still having issues.

   Multiple resident rooms had missing toilets with no drain plug installed, allowing methane gas to come back into the facility.

   The west side stairwell had large pieces of wallpaper missing from the stairway wall.

   Ceiling tiles were water stained or were missing tiles from the dining room area and the facility salon.

   The HVAC unit in the 2nd floor laundry room was actively leaking into a waste basket.

   Occupied resident room 155 had bathroom wall and room door damage from resident wheelchair.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

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

   Comments: The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate).

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

   Comments: The FSEP did not identify specific fire protection actions for residents. There was no section in the plan that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.

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

   Comments: licensed assistant living director (LALD)-A, provided staff training records from a web-based training site, the documentation lacked any record of training on the facility specific fire safety and evacuation plan.