Electronically Delivered

August 20, 2025

Licensee
Valley Ridge
1921 Burnsville Parkway West
Burnsville, MN 55337

RE: Project Number(s) SL28955016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 2, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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

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

Level 2: a fine of $500 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 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. 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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28955	A. BUILDING: _____ B. WING _____	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY RIDGE	1921 BURNSVILLE PARKWAY WEST BURNSVILLE, MN 55337

(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: SL28955016-0 On June 30, 2025, through July 2, 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 52 residents; 52 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

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0 510	Continued From page 1 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to glove use and handwashing by two of four unlicensed personnel (ULP-D, ULP-F). This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: ULP-D On July 1, 2025, at 7:35 a.m., the surveyor observed ULP-D put on gloves prior to setting up medications for R2. ULP-D opened the medication cupboard in R2's room, referenced	0 510		

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0 510	Continued From page 2 the electronic medication administration record (eMAR) on her tablet, set up medications for administration, went to R2's bed where he was lying down. ULP-D assisted R2 with sitting up, and administered oral medications. ULP-D then went to the bathroom, gathered supplies, returned to R2's bed, performed peri-care and applied a topical cream onto R2's penis. ULP-D then emptied R2's overnight catheter bag and switched it to a leg bag. ULP-D went to the bathroom to empty and clean the overnight catheter bag and told R2 that she had to go get more wipes and would be right back to finish assisting R2. ULP-D left R2's room to look for more supplies and then returned to R2's room. ULP-D finished assisting R2 with morning cares and getting dressed, transferred R2 to his wheelchair and brought him to the dining room for breakfast. ULP-D removed gloves and disposed of them in the trash can. ULP-D wore the same pair of gloves while completing all of the above tasks. In addition, ULP-D did not perform hand hygiene after removing gloves. ULP-F On July 1, 2025, at 8:17 a.m., ULP-F applied gloves prior to assisting R1 out of her recliner. ULP-F placed a gait belt on R1, assisted her with transferring from her recliner to her wheelchair. ULP-F brought R1 into the bathroom to complete morning cares. ULP-G went into R1's closet and stated she could not find clean pants. ULP-F stated she would go check the laundry room while ULP-G assisted R1 in the bathroom. ULP-F left R1's room while still wearing gloves and went to the laundry room. As ULP-F returned to R1's room, a Hospice staff member asked ULP-F to unlock the office for her. ULP-F unlocked the	0 510		

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0 510	Continued From page 3 office as requested and then returned to R1's room still wearing the same pair of gloves. Once inside R1's room, ULP-F removed her gloves and put on a new pair. ULP-F did not perform hand hygiene between changing gloves. On July 2, 2024, at 8:24 a.m., clinical nurse supervisor (CNS)-B stated her expectation was for staff to use proper hand hygiene between resident cares, medication administration and following and in between use of gloves. The licensee's Hand Hygiene policy dated 2020, indicated hand hygiene should be performed: a. before and after contact with the resident b. before performing an aseptic task c. after contact with blood or body fluids d. after contact with visibly contaminated surfaces e. after contact with objects in the resident's room f. before donning personal protective equipment g. after removing personal protective equipment h. after using the restroom i. before meals No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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	0 550		

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0 550	Continued From page 4 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, information about the licensee's grievance procedure with the required content. 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 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 June 30, 2025, at 10:15 a.m. during the facility tour with licensed assisted living director (LALD)-A, the surveyor observed the licensee's Quality Concern/Grievance Process posted near the elevators. Although the posted grievance policy included the name, phone number and email of the individual who was responsible for handling resident grievances, it did not include	0 550		

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0 550	Continued From page 5 the contact information for the Office of Ombudsman for Long-Term Care (OOLTC), Office of Ombudsman for Mental Health and Developmental Disabilities (OOMHDD), and Minnesota Adult Abuse Reporting Center (MAARC). On July 2, 2025, at 8:45 a.m., LALD-A reviewed the posted grievance policy and stated it lacked the above content as required. LALD-A stated she was not aware the contact information for OOLTC, OOMHDD and MAARC had to be included on the grievance posting. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
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	0 680		

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0 680	Continued From page 6 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness (EP) plan with all of the required content. This had the potential to affect all residents, staff, and visitors of the assisted living 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 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: The licensee's 2025 Emergency Operations Preparedness Plan was reviewed and lacked the following: - policy and procedure for a system to track the location of on duty staff and sheltered residents and if on duty staff and sheltered residents are relocated, the facility must document the specific name/location of the receiving facility or other location; - evidence the licensee reviewed their Missing	0 680		

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0 680	Continued From page 7 Resident plan on a quarterly basis On July 2, 2025, at 1:56 p.m., licensed assisted living director (LALD)-A reviewed the licensee's emergency preparedness binder and stated it lacked the required content as listed above. LALD-A stated the missing resident plan was reviewed quarterly; however, there was no documentation of when it was reviewed. The licensee's 2025 Emergency Operations Preparedness Plan indicated the licensee's primary goal is to ensure high quality of care and services to the residents by maintaining a safe environment for the residents and staff and the continuity of care and services, even in times of emergency or disaster. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current State Fire Code in Minnesota Rules, chapter 7511. 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	0 775		

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0 775	Continued From page 8 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). Findings include: On July 2, 2025, from 10:30 a.m. to 1:30 p.m., the surveyor toured the facility with maintenance licensed assisted living director (LALD)-A and environmental services director (ESD)-H. During the tour, the surveyor observed: CARBON MONOXIDE ALARM Facility doesn't have carbon monoxide alarms outside of the bedroom's, there is a detector in the main mechanical room. Facility doesn't have fuel fired appliances in the rooms or other areas of the facility. Carbon monoxide alarms should be within 10' on the outside of the sleeping room or at the source of the fuel fired appliance. No proof or documentation was provided or testing confirmation that the facility has any working carbon monoxide alarms. During a facility tour on July 2, 2025, at 12:30 p.m., ESD-H, advised that the facility will be updating the fire alarm panel before the end of the year. ESD-H/LALD-A verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) day.	0 775		
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code;	0 790		

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0 790	Continued From page 9 (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide or maintain fire extinguishers as required throughout the facility. This deficient condition had the ability to affect all staff, visitors, and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) 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 2, 2025, from 10:30 a.m. to 1:30 p.m., the surveyor toured the facility with license assisted living director (LALD)-E and environmental services director (ESD)-H. During the tour, the surveyor observed: FIRE EXTINGUISHER: The portable fire extinguishers throughout the facility showed the required annual service was last completed in June 2024 and overdue for annual service.	0 790		

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0 790	Continued From page 10 On July 2, at 12:30 p.m., LALD-A/ESD-H, verified this deficient finding. TIME PERIOD FOR CORRECTION: Two (2) days.	0 790		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) 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.	0 810		

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0 810	Continued From page 11 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. 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 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: July 2, 2025, from 10:30 a.m. to 1:30 p.m., with LALD-A and ESD-H; provided documents on the FSEP, fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "", undated, failed to include the following: UNIQUE AND UNUSUAL RESIDENT NEEDS: The facility uses an electronic care plan website for standard resident evacuation procedures. The FSEP does not include instructions on how to use or what do in the loss of power/internet event for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents.	0 810		

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0 810	Continued From page 12 On July 2, 2025, at 1:30 p.m., LALD-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TRAINING: The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD-A provided training on 8-30-24 and all other training was completed on a 3rd party website. No other training documentation was provided. On July 2, 2025, at 1:30 p.m., LALD-A stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing;	01370		

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01370	Continued From page 13 (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency was completed for one of two employees (unlicensed personnel (ULP)-C) to include all required content. 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	01370		

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01370	Continued From page 14 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: ULP-C was hired on January 22, 2025, to provide direct care and services to the facility's residents. On June 30, 2025, at 1:30 p.m., the surveyor observed ULP-C administer medications to R1. ULP-C's employee record lacked evidence of training on the following topics: -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional On July 2, 2025, at 2:04 p.m., human resource manager (HRM)-I reviewed ULP-C's Relias (an online education program) transcript and orientation training documents and stated ULP-C's record lacked evidence of completing the required training as noted above. The licensee's Education and Training policy dated April 2022, indicated employees would receive orientation and ongoing training to assure they possess the competencies, and skill sets necessary to provide services to meet the resident's needs safety and in a manner that promotes each resident's rights, physical, mental and psychosocial well-being. Competency-based training will be consistent with their expected job roles, policies and procedures, position description and to met professional standards of practice. No further information was provided.	01370		

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01370	Continued From page 15 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
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	01500		

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01500	Continued From page 16 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 observation, 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)-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, 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 17 The findings include: ULP-D was hired on February 21, 2024, to provide direct care and services to the facility's residents. On July 1, 2025, at 7:35 a.m., the surveyor observed ULP-D administer medications to R2. ULP-D's employee record lacked evidence the employee had successfully completed annual training as required, to include the following: - Reporting maltreatment of vulnerable adults or minors - Assisted Living bill of rights On July 2, 2025, at 2:09 p.m., human resource manager (HRM)-I reviewed ULP-D's Relias (an online education program) transcript and annual training documents and stated ULP-D's record lacked evidence of completing the required training as noted above. On July 2, 2025, at 2:30 p.m., clinical nurse supervisor (CNS)-B stated she received an email that indicated ULP-D had received the required annual training as listed above. The surveyor requested evidence of the completed annual training; however, it was not provided. The licensee's Education and Training policy dated April 2022, indicated employees would receive orientation and ongoing training to assure they possess the competencies, and skill sets necessary to provide services to meet the resident's needs safety and in a manner that promotes each resident's rights, physical, mental and psychosocial well-being. Competency-based training will be consistent with their expected job	01500		

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01500	Continued From page 18 roles, policies and procedures, position description and to meet professional standards of practice. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01750 SS=E	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, 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 records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse documented resident-specific instructions for three of three residents (R1, R2, and R3) whose medication administration was delegated to unlicensed personnel (ULP). 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	01750		

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01750	Continued From page 19 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: R1 R1 was admitted on April 14, 2025, with diagnoses that included acute respiratory failure with hypoxia (condition where you don't have enough oxygen in the tissues in your body). On June 30, 2025, at 1:30 p.m., the surveyor observed ULP-C administer medications to R1. R1's service plan dated June 4, 2025, indicated R1 received services to include medication administration. CONSTIPATION R1's Medication Administration Record (MAR) dated June 2025, included: -bisacodyl suppository 10 milligrams (mg); administer one suppository per rectum daily as needed for constipation -Miralax 17 grams (g); Dissolve 17 g of powder mixed with water/juice and administer by mouth daily as needed for constipation The licensee failed to provide instructions for the ULP to understand which PRN (as needed) medication for constipation should be used in which order. PAIN R1's MAR dated June 2025, included: -Tylenol 650 mg; take two tablets by mouth every six hours as needed for pain	01750		

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01750	Continued From page 20 -hydromorphone 1 mg; give one solutab by mouth/under tongue every hour as needed for pain or shortness of breath The licensee failed to provide instructions for the ULP to understand which PRN medication for pain should be used in which order. ANXIETY R1's MAR dated June 2025, included: -lorazepam 0.5 mg; give one solutab by mouth/under tongue every four hours as needed for anxiety or dyspnea (shortness of breath) -haloperidol 1 mg; give one solutab by mouth/under tongue every four hours as needed for terminal restlessness or anxiety The licensee failed to provide instructions for the ULP to understand which PRN medication for anxiety should be used in which order. SHORTNESS OF BREATH R1's MAR dated June 2025, included: -hydromorphone 1 mg; give one solutab by mouth/under tongue every hour as needed for pain or shortness of breath -lorazepam 0.5 mg; give one solutab by mouth/under tongue every four hours as needed for anxiety or dyspnea (shortness of breath) The licensee failed to provide instructions for the ULP to understand which PRN medication for shortness of breath should be used in which order. R2 R2 was admitted on January 23, 2023, with diagnoses that included dementia. On July 1, 2025, at 7:35 a.m., the surveyor	01750		

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01750	Continued From page 21 observed ULP-D administer medications to R2. R2's service plan dated March 14, 2025, indicated R2 received services to include medication administration. CONSTIPATION R2's MAR dated June 2025, included: -milk of magnesia suspension 500/5 milliliters (ml); take 60 ml twice daily as needed for constipation -senna 8.6 mg; take one tablet twice daily as needed for constipation The licensee failed to provide instructions for the ULP to understand which PRN medication for constipation should be used in which order. PAIN -acetaminophen 500 mg; administer two tablets by mouth two times a day as needed for pain -Morphine 5 mg; administer one solutab by mouth every four hours as needed for pain The licensee failed to provide instructions for the ULP to understand which PRN medication for pain should be used in which order. R3 R3 was admitted on March 8, 2024, with diagnoses that included diabetes. On July 1, 2025, at 8:36 a.m., the surveyor observed ULP-E administer medications to R3. R3's service plan dated April 19, 2025, indicated R3 received services to include medication administration. R3's MAR dated June 2025, included:	01750		

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01750	Continued From page 22 -albuterol inhaler 90 micrograms (mcg); inhale two puffs every six hours as needed for shortness of breath or cough -benzonatate 100 mg; give one capsule by mouth up to three times daily as needed for cough -guaifenesin 400 mg; take one tablet every four hours as needed for cough The licensee failed to provide instructions for the ULP to understand which PRN medication for cough should be used in which order. On July 2, 2025, at 8:38 a.m., clinical nurse supervisor (CNS)-B stated R1, R2, and R3's record did not include resident-specific directions for the ULP on which order to give the PRN medications as noted above. The licensee's Medication Management policy dated Jun 25, 2025, indicated a registered nurse (RN) may delegate mediation administration to resident assistants only after the RN has: a. verified the resident assistant is education and trained in the proper methods to administer the medications, and the resident assistant has demonstrated the ability to competently follow the procedures b. developed specific written instructions for each resident and document those instructions in the resident's medication administration record c. communicated with the resident assistant about the individual needs of the resident d. the medication is in the original pharmacy-dispensed container with a proper label and directions, in the original over-the-counter container, bubble pack, or the medication has been removed from the original container and placed in a unit container by a licensed nurse.	01750		

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01750	Continued From page 23 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01940 SS=F	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.	01940		

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01940	Continued From page 24 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 two of two residents (R1 and 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, 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: R1 R1 was admitted on April 14, 2025, with diagnoses that included acute respiratory failure with hypoxia (condition where you don't have enough oxygen in the tissues in your body). On June 30, 2025, at 1:18 p.m., the surveyor observed unlicensed personnel (ULP)-C switch R1's oxygen from a portable tank to a concentrator at 2 liters via nasal cannula. R1's service plan dated June 4, 2025, indicated R1 received services to include daily oxygen saturation checks and oxygen management. R1's signed prescriber orders dated June 15, 2025, included: -oxygen concentrator with bubble at 2 liters nasal cannula continuous flow -oxygen saturation; obtain daily readings and as	01940		

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VALLEY RIDGE	1921 BURNSVILLE PARKWAY WEST BURNSVILLE, MN 55337

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01940	Continued From page 25 needed R1's record lacked a treatment management plan to include the following required content: - statement of the type of service that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse when a problem arose with treatments or therapy services; and - 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. R3 R3 was admitted on March 8, 2024, with diagnoses that included diabetes. On July 1, 2025, at 8:36 a.m., the surveyor observed ULP-E check R3's blood sugar. R3's service plan dated April 19, 2025, indicated R3 received services to include blood sugar checks, Velcro wraps and weight monitoring. R3's signed prescriber orders dated February 20, 2025, included: -Blood sugar checks daily -Velcro Wraps with morning and bedtime cares -Weight monitoring three times a week R3's record lacked a treatment management plan to include the following required content:	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28955	A. BUILDING: _____ B. WING _____	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY RIDGE	1921 BURNSVILLE PARKWAY WEST BURNSVILLE, MN 55337

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01940	Continued From page 26 - statement of the type of service that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse when a problem arose with treatments or therapy services; and - 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. On July 2, 2025, at 8:29 a.m., clinical nurse supervisor (CNS)-B stated R1 and R3's treatments were listed on their service plans. CNS-B stated residents receiving treatments did not have an individualized treatment management plan. The licensee's Treatment and Therapy Management policy dated March 7, 2023, indicated the licensee provides therapy/treatments to residents as needed based on request, physician orders, or clinical assessment. The therapy/treatment is to be provided according to licensee policy and standards of practice. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

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	28955	A. BUILDING: _____ B. WING _____	07/02/2025

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02310	Continued From page 27	02310		
02310 SS=D	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 standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure care and services were provided according to acceptable health care and medical or nursing standards for one of one resident (R3) with bed rails. 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). R3 was admitted on March 8, 2024, with diagnoses that included diabetes. R3's service plan dated April 19, 2025, indicated R3 received services to include extensive assist AM (morning), standard assistance PM (evening), shower, incontinent assistance, transfers, escorts, blood sugar checks, insulin, Velcro wraps and medication administration. On July 1, 2025, at 10:36 a.m., R3's bed was observed with bilateral halo bed rails. R3 stated she didn't use the halo bars because she has	02310		

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02310	Continued From page 28 never slept in her bed and prefers to sleep in her recliner. R3 stated her children want her to sleep in bed and had the halo bars installed in case she decided to sleep in bed. R3's comprehensive nursing assessment dated April 12, 2025, did not include R3's use of halo bed rails. On July 2, 2025, at 11:03 a.m., clinical nurse supervisor (CNS)-B reviewed R3's comprehensive assessment and stated it did not include R3's use of halo bed rails. CNS-B stated the comprehensive assessment should have included that R3 had bilateral halo bed rails attached to her bed. CNS-B stated R3's bed rail information may have been removed from the assessment because R3' did not want the bed rails and never used the bed rails because she has never slept in her bed. CNS-B stated R3's family requested to keep the bed rails in place in case R3 changed her mind and wanted to sleep in her bed in the future. R3's record lacked: - an assessment for the current bed rail use; - documentation of risk vs. benefits education discussion with R3 or R3's responsible party; - documentation R3's bed rail was used, installed, and maintained per manufacturer's instructions; and - documentation R3's bed rail was checked for recalls with the Consumer Product Safety Commission (CPSC). The licensee's Physical Device policy dated July 31, 2024, indicated : -the use of any physical device will be reviewed and discussed at or prior to the start of care, with each clinical update (with every routine	02310		

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02310	Continued From page 29 assessment and with significant change) and with initiation of a new device when facility is made aware, to determine if the device is still needed to enhance the resident's safety and/or bed mobility. -the staff would install bed assistive devices on personal beds under the following guidelines: -the resident has been clinically assessed for appropriate use of the device -the resident and/or responsible party has been educated regarding the risks and benefits of the physical device -the resident and/or responsible party have agreed to the use and installation of the device as intended per manufacturer's recommendations and understand the risks of physical devices -the resident and/or responsible party has agreed t pay for the installation and maintenance of the device by the engineering staff -the manufacturer's guidelines have been provided to the licensee's staff and when installed device and bed meet FDA requirements for zones of entrapment. -during installation, annual review, and change of assistive device, engineering will physically inspect for areas of entrapment, ensure device meets FDA requirements for zones of entrapment, check the stability of the device and ensure the device is installed per manufacturer's guidelines. Annual review will happen in conjunction with routine apartment inspections, which will be triggered through licensee's work order system The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain,	02310		

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02310	Continued From page 30 uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe". The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements".	02310		

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02310	Continued From page 31 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) Days	02310		

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

Food & Beverage Inspection Report

Establishment Info

Valley Ridge
1921 Burnsville Parkway West
Burnsville, MN 55337
Dakota County
Parcel:

Phone:

License Info

License: HFID 28955

Risk:
License:
Expires on:
CFPM: Lisa Hoffart
CFPM #: 24672; Exp: 10-24-2027

Inspection Info

Report Number: F1018251018
Inspection Type: Full - Single
Date: 6/30/2025 Time: 8:07:18 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

Kitchen serves approximately 56 residents daily.

Discussed employee illness reporting and reviewed illness log.

Discussed cooking procedures, cooling procedures and date marking.

Establishment has a satellite kitchen for memory care on each of the 3 floors. Food is taken from the main kitchen and served in the satellite kitchens. All dishes are done in the main kitchen dish room. Dishwashers in satellite kitchens are not used.

Front of kitchen has a small cafe with prepackaged items that are brought in from a manufacturer. The cafe is still under the same license at the main facility.

No orders issued.

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

I acknowledge receipt of the Metro District Office inspection report number F1018251018 from 6/30/2025

Rebecca Prestwood

Lisa Hoffart
Kitchen Manager

Rebecca Prestwood, REHS
Public Health Sanitarian 3
651-201-3777
rebecca.prestwood@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

Valley Ridge
Burnsville
County/Group: Dakota County

Inspection Info

Report Number: F1018251018
Inspection Type: Full
Date: 6/30/2025
Time: 8:07:18 PM

Food Temperature: Product/Item/Unit: Tomato**; Temperature Process:** Cold-Holding
Location: Prep Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

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

Food Temperature: Product/Item/Unit: Eggs**; Temperature Process:** Cold-Holding
Location: Prep Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Cheese**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Roast Beef**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 39 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Soup**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 38 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: Mem Care Cooler 1**; Temperature Process:**
Location: Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: Mem Care Cooler 2**; Temperature Process:**
Location: Cooler at 39 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: Mem Care Cooler 3**; Temperature Process:**
Location: Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

Valley Ridge
Burnsville
County/Group: Dakota County

Inspection Info

Report Number: F1018251018
Inspection Type: Full
Date: 6/30/2025
Time: 8:07:18 PM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 165 Degrees F.
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Sink and Surface**; Sanitizing Process:** 3-Compartment Sink
Location: Dishwashing Area **Equal To** 700 PPM
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Sink and Surface**; Sanitizing Process:** Wiping Cloth Bucket
Location: Cook Line **Equal To** 700 PPM
Comment:
Violation Issued?: No