Electronically Delivered

August 7, 2026

Licensee
Chosen Valley Assisted Living
1260 Winona Street Southeast
Chatfield, MN 55923

RE: Project Number(s) SL30494016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 9, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

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

St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $500.00

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

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

The correction order documentation should include the following:

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

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

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

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

factor.

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

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers.

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

If you have any questions, please contact me.

Sincerely,

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
	30494	A. BUILDING: _____ B. WING _____	07/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOSEN VALLEY ASSISTED LIVING	1260 WINONA STREET SE CHATFIELD, MN 55923

(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: SL30494016-0 On July 6, 2026 through July 9, 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 16 resident(s); 15 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. 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.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 7, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the 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 one of two unlicensed personnel (ULP-E) during personal cares. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).	0 510		

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0 510	Continued From page 4 The findings include: On July 7, 2026, at 8:35 a.m., the surveyor observed ULP-E assist R8 to transfer to her wheelchair, wheeled her to the bathroom, and provided standby assistance for R8 to transfer to the toilet. ULP-E donned gloves and assisted R8 to remove her pants and wet incontinent brief. ULP-E continued with the same gloves, wet a clean washcloth and wash R8's back. ULP-E then answered a phone call (still wearing the same gloves) and stated she needed to assist another resident who had pressed their pendant. ULP-E removed her gloves, opened R8's door, and left R8's apartment. ULP-E then headed to the location of the call but was called off by another staff member as the resident was fine. ULP-E returned to R8's apartment, donned clean gloves and resumed R8's cares, assisting with dressing and transferring to her wheelchair. ULP-E removed her gloves and went to the computer to document the tasks completed. ULP-E then used hand sanitizer before leaving R8's apartment. ULP-E did not remove her gloves and complete proper handwashing between the steps of removing a urine soiled incontinent brief, performing other cares and touching other surfaces, and further failed to sanitize her hands following removal of soiled gloves. On July 8, 2026, at 3:50 p.m., registered nurse (RN)-B stated she expected all staff to remove gloves and sanitize hands immediately following management of soiled incontinent briefs and before touching other surfaces or continuing with other personal cares. The licensee's Glove Use policy dated June 2021, indicated when conducting a procedure	0 510		

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0 510	Continued From page 5 requiring the use of gloves, proper hand hygiene should be completed before donning gloves and after removing gloves. The licensee's Handwashing policy dated June 2021, indicated hand washing will be performed by all employees, as necessary, between tasks and procedures, and after bathroom use, to prevent cross-contamination. No other 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 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	0 550		

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0 550	Continued From page 6 review, the licensee failed to post the required information related to the grievance procedure as well as the required information related to the contact information for the state and applicable regional Office of Ombudsman for Mental Health and Developmental Disabilities. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 July 6, 2026, at 12:45 p.m., the surveyor observed the licensee's postings. The licensee's Grievance Procedure was posted; however, the procedure lacked the required content to include the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. Additionally, the posting lacked contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities and lacked information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. On July 6, 2026, at 12:50 p.m., registered nurse (RN)-B stated she was not aware the required postings were missing and would ensure the postings were corrected.	0 550		

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0 550	Continued From page 7 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 775 SS=E	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, record review, and interview, 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 two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated July 9, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.	0 775		

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0 775	Continued From page 8 TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
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 9 This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, 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 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, Physical Environment Inspection Report (PEIR) dated July 9, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup.	01770		

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01770	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included the required content for one of one resident (R8). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on July 6, 2026, at 11:15 a.m., registered nurse (RN)-B stated the licensee provided medication management services to their residents, including medication setup. R8's Service Plan dated May 13, 2026, indicated she received medication reminders and medication set up the facility nurse. R8's medication administration record (MAR) dated July 2026, indicated she received one medication for the thyroid, one for blood pressure, one for fluid retention, one for constipation, one for seizures, one for mild pain, one eye drop, and three supplements. R8's unlabeled, document known as the licensee's task documentation record dated June 4, 2026, June 18, 2026, and July 2, 2026, indicated the licensed practical nurse completed medication set up. The document included a	01770		

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01770	Continued From page 11 checkmark for the task; however, it did not indicate what medications were set up and for what dates. R8's record lacked documentation by the licensed nurse at the time of setup to include the name of medication, quantity of dose, times to be administered, and route of administration as required. On July 8, 2026, at 12:20 p.m., RN-B stated the licensee set up most resident's medications for them in pill boxes and the licensee documented the task of set-up on the task record with the assumption the medication administration record was followed to include the required content. She stated this would be how all resident medication set up was documented. The licensee's Medication Management-Dosage Box Set-up policy dated June 2021, indicated the licensed nurse sets up medication on weekly into the dosage boxes. When the licensed nurse has completed setting up the medications into the dosage box, the set-up is documented on the MAR. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	01770		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.	01880		

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	30494	A. BUILDING: _____ B. WING _____	07/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOSEN VALLEY ASSISTED LIVING	1260 WINONA STREET SE CHATFIELD, MN 55923

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01880	Continued From page 12 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the licensee's medication refrigerator was maintained at an acceptable temperature to ensure the medications were stored according to manufacturer's recommendations for two of two residents (R1, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 6, 2026, at 11:15 a.m. during entrance conference, registered nurse (RN)-B stated resident medications were securely stored locked boxes in each resident apartment, medications for refill were stored in a locked office space, and medications that required refrigeration were stored in a small refrigerator in a locked office space. MEDICATION REFRIGERATOR TEMPERATURE On July 7, 2026, at 12:50 p.m., the surveyor and RN-B reviewed the contents of the licensee's small medication refrigerator found in a locked office area. The refrigerator included a thermometer sitting on the top shelf and read 39 degrees Fahrenheit (F). RN-B stated no temperature monitoring had been completed as	01880		

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01880	Continued From page 13 she was not aware of the requirement. The medications stored within the refrigerator included: -R1-six pens-Trulicity 3 milligrams (mg)/0.5 milliliter (ml) injectable pen for type two diabetes. The package instructions indicated to store the pens at 36-46 degrees F; -R5 Rhopressa 0.002% eye drops, one opened bottle (no open date) and 14 unopened bottles; -R5 latanoprost 0.005% eye drops, one opened bottle (no open date); -R5 dorzolamide-timolol 22.3-6.8 mg/ml eye drops, one opened bottle, one unopened bottle; -R5 prednisolone 1% eye drops, one opened bottle (no open date); -R5 atropine 1% two opened bottles (no open date); and -R5 brimonidine 0.2 % one opened bottle (open date) Rhopressa manufacturer's instructions dated October 2024, indicated Storage: Store at 2°C to 8°C (36°F to 46°F) until opened. After opening, the product may be kept at 2°C to 25°C (36°F to 77°F) for up to 6 weeks. If after opening the product is kept refrigerated at 2°C to 8°C (36°F to 46°F), then the product can be used until the expiration date stamped on the bottle. Latanoprost manufacturer's instructions dated November 2010, indicated storage at 36-46 degrees F until opened. After opening, the product may be stored at a temperature of 77 degrees F for up to six weeks. Dorzolamide-timolol manufacturer's instructions dated June 2026, indicated store dorzolamide hydrochloride and timolol maleate ophthalmic solution at 68° to 77°F. Protect from light. After	01880		

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01880	Continued From page 14 opening, dorzolamide hydrochloride and timolol maleate ophthalmic solution can be used until the expiration date on the bottle. Prednisolone package instructions indicated store at 46-76 degrees F. Atropine manufacturer's instructions dated July 2025, indicated to store at 68-77 degrees F. Brimonidine manufacturer's instructions dated March 2016, indicated to store at 59-77 degrees F. The licensee did not ensure medications were stored at the recommended temperature. On July 7, 2026, at 12:55 p.m., RN-B stated R5's eye medications were currently on hold, and the licensee was storing them all in the refrigerator in the event the drops were restarted. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs 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:	01890		

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01890	Continued From page 15 Based on observation, interview, and record review, the licensee failed to label a time sensitive medication with an opened date for one of one resident (R8) with time sensitive medications. 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 included: R8's Service Plan dated May 13, 2026, included the services of medication set-up/management/administration. R8's signed prescriber's orders dated June 11, 2026, included Refresh eye drops, give one drop in both eyes twice daily. On July 7, 2026, at 8:10 a.m., the surveyor observed unlicensed personnel (ULP)-E administer R8's Refresh eye drops and administer her oral medications. The Refresh eye drops lacked an open date. ULP-E confirmed the drops lacked an open date. Refresh eye drop manufacturer's dated March 2024, indicated discard 30 days after opening. On July 8, 2026, at 12:55 p.m., registered nurse (RN)-B stated she would work with staff to ensure time sensitive medications included an open date when appropriate.	01890		

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01890	Continued From page 16 The licensee's Storage of Medications policy dated June 2021 indicated medications would be stored according to manufacturer's instructions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The	01940		

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01940	Continued From page 17 treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions and documented those instructions in the resident record for one of one resident (R3) with treatments/delegated tasks. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on July 6,2026, at 11:15 a.m., registered nurse (RN)-B stated the licensee provided treatment and therapy services to residents as prescribed. R3 began receiving services on December 1, 2023, with diagnoses including type two diabetes. R3's Service Plan dated May 21, 2026, included the service of compression stockings. On July 7, 2026, at 7:00 a.m., the surveyor observed unlicensed personnel (ULP)-E don R3's compression stockings to both lower extremities. The surveyor and ULP-E reviewed the licensee's	01940		

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01940	Continued From page 18 electronic medical record system (EMR) and noted no additional instructions regarding the compression stockings were present other than donning and removing. R3's signed prescriber's order dated April 13, 2026, indicated compression stockings on in the morning and removed in the evening. R3's Care History (known as task documentation) dated July 2026, indicated to place compression stockings on in the morning and remove in the evening. The RN did not specify in writing, specific instructions and documented those instructions in the resident record for the ULP to notify the nurse if there were noted concerns with R3's use of compression stockings such as redness, swelling or broken skin. On July 8, 2026, at 3:25 p.m., RN-B stated she had not considered compression stockings as a treatment. She further stated she had written specific instructions for other treatments provided to residents but had not done so for the three residents currently using compression stockings. The licensee's Medication and Treatment-Administration and Delegation policy dated June 2021, indicated the nurse has specified, in writing, specific instructions for each resident and documented those instructions in the resident's records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01940		

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

Food & Beverage Inspection Report

Establishment Info

Chosen Valley Assisted Living
1260 WINONA STREET SE
Chatfield, MN 55923
Fillmore County
Parcel:

Phone: 507-429-9626
diet@cvslhome.com

License Info

License: HFID 30494
Jada Blom
Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1045261103
Inspection Type: Full - Single
Date: 7/7/2026 Time: 11:36:10 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 2
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:
Firm provided inspector with a certificate of achievement from a ServSafe course for Ms. Jada Blom. Discussed requirements in order to get a MN CFPM for current operations. Included info in an email
Comply By: 7/7/2026 Originally Issued On: 7/7/2026

! **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:
The upright Cooler in the dining area was observed holding product at elevated temperatures. Desert - 43F
*Temp log showed temps of 50F for multiple days of storage with no comments on any repairs/adjustments being made.
Monitor this unit and ensure it maintains product below 41F... recommend taking internal product temperatures
Comply By: 7/7/2026 Originally Issued On: 7/7/2026

New Order: 4-500 Equipment Maintenance and Operation
4-501.12 *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0740 Resurface scratched or scored cutting blocks and boards or discard if they can no longer be effectively cleaned and sanitized or resurfaced.
COMMENT:
White cutting board located at steam table was observed deeply scratched/scored.
Comply By: 7/28/2026 Originally Issued On: 7/7/2026

Food & Beverage General Comment

Assisted Living Kitchen supplied by the Care Center. Food is served from the space only and all leftovers are either given to staff or tossed at end of service period.

Reviewed: Ill employee policy, proper handwashing, no barehand contact requirements with ready to eat foods, temperature monitoring

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 F1045261103 from 7/7/2026

Jada Blom
Dietary Lead

Nicole Hunger,
Public Health Sanitarian 3
507-206-2741
nicole.hunger@state.mn.us

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL30494016-0	**Date:** July 9, 2026
Facility Name: Chosen Valley Assisted Living	
Facility Address: 1260 Winona Street SE, Chatfield, MN 55923	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Pattern **TIME PERIOD OF CORRECTION:** Seven (7) 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. In buildings that contain a fuel-burning appliance or fireplace, or attached private garage, carbon monoxide detection shall be installed in dwelling units within ten feet of bedrooms. Where a fuel burning appliance is located in a bedroom or its attached bathroom, carbon monoxide detection shall be installed within the bedroom. Carbon monoxide detection can be provided by carbon monoxide alarms installed in dwelling or sleeping units or a carbon monoxide detection system installed in the room or space that contains the fuel-burning appliance. [Minn. Stat. 144G.45 subd. 2; MSFC 915]

   Comments: The building contained gas fired mechanical equipment. A carbon monoxide detection system was not installed, and carbon monoxide alarms were not provided within ten feet of all resident bedrooms.

3. Fire doors shall be maintained to be self-closing and latch as designed. Fire doors shall not be blocked, obstructed, or otherwise made inoperable. [Minn. Stat. 144G.45 subd. 2; MSFC 705]

   Comments: The door closer had been disconnected from the labeled fire door for the life enrichment office on the second floor. Fire doors shall be maintained to contain fire and smoke in the event of an emergency.

4. Extension cords and flexible cords shall not be a substitute for permanent wiring. [Minn. Stat. 144G.45 subd. 2; MSFC 604.5]

   Comments:
   - An orange extension cord was used to supply power to equipment in nurse office room 125
   - An extension cord was used in resident room 106 to supply power to personal electronics.

☒ **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 (FSEP) that include 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. [Minn. Stat. 144G.45 subd.2]

   Comments: The provided fire safety and evacuation plan (FSEP) failed to include evacuation procedures for the individualized unique needs of residents. The licensee stated the resident evacuation procedures were maintained electronically. These individualized resident procedures would not be easily accessible to staff or emergency responders during a fire or similar emergency.

2. Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. [Minn. Stat. 144G.45 subd.2]

   Comments: The surveyor requested records for evacuation drills completed in the past year from maintenance staff (MS)-G. A fire drill plan of correction was provided. MS-G stated no drill logs were available as the employee who was responsible for managing fire drills was out on leave. Record review of the available documentation indicated the licensee failed to meet the evacuation drill frequency.