Electronically Delivered

April 2, 2026

Licensee
Valleyview of Northfield
812 Linden Street North
Northfield, MN 55057

RE: Project Number(s) SL30330016

Dear Licensee:

On March 25, 2026, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on February 20, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the February 20, 2025 survey.

The Department of Health 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.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on February 20, 2025, found not corrected at the time of the March 25, 2026, follow-up survey and/or subject to penalty assessment are as follows:

2310-Appropriate Care And Services-144g.91 Subd. 4 (a) - $500.00

The details of the violations noted at the time of this follow-up survey completed on March 25, 2026 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

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.

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.

We urge you to review these orders carefully. If you have questions, please contact Jodi Johnson at 507-344-2730.

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

Sincerely,



Jodi Johnson, Supervisor
State Rapid Response Team / State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-800-337-9238 / 1-866-890-9290

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30330	A. BUILDING: _____ B. WING _____	R 03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEYVIEW OF NORTHFIELD	812 LINDEN STREET N NORTHFIELD, MN 55057

(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL30330016-2 On March 24, 2026, through March 25, 2026, the Minnesota Department of Health conducted a desk follow-up survey for the above provider to follow-up on orders issued pursuant to a survey completed on August 13, 2025. At the time of the survey, there were 38 residents receiving services under the Assisted Living Facility license. As a result of the follow-up survey, the following orders were reissued: 2310.	{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.	
{0 345} SS=C	144G.30 Subd. 5. (c)(2), (d) Correction orders (c)(2) make available, in a manner readily	{0 345}		

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{0 345}	Continued From page 1 accessible to residents and others, including provision of a paper copy upon request, the most recent plan of correction documenting the actions taken by the facility to comply with the correction order. (d) After the plan of correction is made available under paragraph (c), clause (2), the facility must provide a copy of the facility's most recent plan of correction to any individual who requests it. A copy of the most recent plan of correction must be provided within 30 days after the request and in a format determined by the facility, except the facility must make reasonable accommodations in providing the plan of correction in another format, including a paper copy, upon request. This MN Requirement is not met as evidenced by:	{0 345}	Not reviewed during this survey.	
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part	{0 480}		

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{0 480}	Continued From page 2 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 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:	{0 480}		

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{0 480}	Continued From page 3	{0 480}	Not reviewed during this survey.	
{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:	{0 775}	Not reviewed during this survey.	
{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	{0 810}		

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{0 810}	Continued From page 4 training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}	Not reviewed during this survey.	
{01620} SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation	{01620}		

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{01620}	Continued From page 5 of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by:	{01620}	Not reviewed during this survey.	
{01640} SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must	{01640}		

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{01640}	Continued From page 6 include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by:	{01640}	Not reviewed during this survey.	
{01650} SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service	{01650}		

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{01650}	Continued From page 7 cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by:	{01650}	Not reviewed during this survey.	
{01730} SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's	{01730}		

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{01730}	Continued From page 8 directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by:	{01730}	Not reviewed during this survey.	
{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	{01940}		

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{01940}	Continued From page 9 statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by:	{01940}	Not reviewed during this survey.	
{02310} SS=F	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.	{02310}		

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{02310}	Continued From page 10 This MN Requirement is not met as evidenced by: Based on 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 two of two residents (R3, R11) 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 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: R3 R3 was admitted on January 25, 2023. R3's Side Rail assessment dated January 27, 2026, for hospital-style bed rails lacked zone measurements as required by the United States Food and Drug Administration (FDA) to prevent entrapment and death. R11 R11 was admitted on July 1, 2025. R11's Side Rail assessment dated January 27, 2026, for hospital-style bed rails lacked zone measurements as required by the United States Food and Drug Administration (FDA) to prevent entrapment and death.	{02310}		

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{02310}	Continued From page 11 On March 25, 2026, at 9:11 a.m., licensed assisted living director (LALD)-A stated the licensee's side rail assessments lacked a section for documentation related to measuring all FDA required zones. LALD-A stated the licensee is working with the current software to add all the FDA zones to be measured. The licensee's Side rails policy dated August 1, 2024, indicated the licensee would measure and document the FDA identified zones when hospital-style bed rails were in use. No further information provided.	{02310}		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 26, 2025

Licensee
Valleyview of Northfield
812 Linden Street North
Northfield, MN 55057

RE: Project Number(s) SL30330016

Dear Licensee:

On August 13, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on February 20, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the February 20, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on February 20, 2025, found not corrected at the time of the August 13, 2025, follow-up survey and/or subject to penalty assessment are as follows:

1620-Initial Reviews, Assessments, And Monitoring-144g.70 Subd. 2 (c-E) - $500.00
1640-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (a-E) - $500.00
1650-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (f) - $500.00
1730-Individualized Medication Management Plan-144g.71 Subd. 5 - $500.00
1940-Individualized Treatment Or Therapy Managemen-144g.72 Subd. 3 - $500.00
2310-Appropriate Care And Services-144g.91 Subd. 4 (a) - $1,000.00

The details of the violations noted at the time of this follow-up survey completed on August 13, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on August 13, 2025, we identified the following violation(s):

0345-Correction Orders-144g.30 Subd. 5. (c)(2), (d)

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,500.00**. 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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

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.

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.

We urge you to review these orders carefully. If you have questions, please contact Jodi Johnson at 507-344-2730.

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

Sincerely,



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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30330	A. BUILDING: _____ B. WING _____	R 08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEYVIEW OF NORTHFIELD	812 LINDEN STREET N NORTHFIELD, MN 55057

(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL30330016-1 On August 12, 2025, through August 13, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on February 20, 2025. At the time of the survey, there were 34 residents receiving services under the Assisted Living Facility license. As a result of the follow-up survey, the following orders were reissued.	{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.	
0 345 SS=C	144G.30 Subd. 5. (c)(2), (d) Correction orders	0 345		

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0 345	Continued From page 1 (c)(2) make available, in a manner readily accessible to residents and others, including provision of a paper copy upon request, the most recent plan of correction documenting the actions taken by the facility to comply with the correction order. (d) After the plan of correction is made available under paragraph (c), clause (2), the facility must provide a copy of the facility's most recent plan of correction to any individual who requests it. A copy of the most recent plan of correction must be provided within 30 days after the request and in a format determined by the facility, except the facility must make reasonable accommodations in providing the plan of correction in another format, including a paper copy, upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written plan of correction (POC) documenting the actions taken by the licensee to address correction orders issued for the licensee's survey completed February 20, 2025. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). On March 27, 2025, the licensee was provided the results of their survey along with the form 2567 (a form on which citations are documented	0 345		

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0 345	Continued From page 2 with findings of the survey). On August 12, 2025, at 12:00 p.m., the surveyor requested a copy of the licensee's documented POC related to the previous survey. Licensed assisted living director (LALD)-A stated the licensee had not developed a written POC but had been using the previous survey 2567 to address citations. LALD-A stated the licensee had completed a POC for a survey exited in 2022 but had not completed one for the most recent survey. LALD-A stated the licensee would need to develop and document a POC. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 345		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed	{0 480}		

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{0 480}	Continued From page 3 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 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:	{0 480}	Not reviewed during this survey.	

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{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:	{0 775}	Not reviewed during this survey.	
{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	{0 810}		

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{0 810}	Continued From page 5 per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}		
{01620} SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's	{01620}	Not reviewed during this survey.	

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{01620}	Continued From page 6 needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing nursing assessments not to exceed 90 days for two of five residents (R2 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	{01620}		

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{01620}	Continued From page 7 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: R2 R2 was admitted on March 13, 2023. R2's Initial Unified Assessment was completed on April 21, 2025. A total of 113 days had passed since R2's most recent assessment, thus exceeding 90 days. R3 R3 was admitted on January 25, 2023. R3's Initial Unified Assessment was completed on April 21, 2025. A total of 113 days had passed since R2's most recent assessment, thus exceeding 90 days. On August 12, 2025, at 2:40 p.m., clinical nurse supervisor (CNS)-B stated the licensee had updated their electronic health record (EHR) and since the update, CNS-B has been behind in completing all assessments within the required time frame. CNS-B stated they had been working on assessments weekly but all assessments for each resident had not been updated and brought into compliance yet. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated August 1, 2024, indicated ongoing resident assessments would not exceed 90 calendar days from the date of the previous	{01620}		

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{01620}	Continued From page 8 assessment. No further information provided.	{01620}		
{01640} SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a written service plan was signed to reflect the current services provided for three of five residents (R2, R3, and R10).	{01640}		

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{01640}	Continued From page 9 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: R2 R2 was admitted on March 13, 2023. R2's record lacked an authenticated service plan to agree upon services to be provided. R3 R3 was admitted on January 25, 2023. R3's record lacked an authenticated service plan to agree upon services to be provided. R10 R10 was admitted on May 20, 2025. R10's record lacked an authenticated service plan to agree upon services to be provided. On August 13, 2025, at 9:20 a.m., licensed assisted living director (LALD)-A stated the licensee had not developed and obtained authentication on a service plan for R2, R3, and R10. LALD-A stated the licensee had historically completed service plans with all required content, but when licensee updated their electronic health record (EHR), the licensee believed the software	{01640}		

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{01640}	Continued From page 10 would develop new service plans for residents, but the EHR did not. LALD-A stated that since the EHR did not develop the service plans, no authentication was obtained from the residents to agree upon services. The licensee's 6.08 Service Plan policy dated August 1, 2024, indicated service plans and any revisions would include authentication by the licensee and the resident or resident's designated representative to document agreement of services to be provided. No further information provided.	{01640}		
{01650} SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has	{01650}		

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{01650}	Continued From page 11 authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a written service plan was developed with all required content for three of five residents (R2, R3, and R10). 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: R2, R3, and R10 were admitted on March 13, 2023, January 25, 2023, and May 20, 2025, respectively. R2's Initial Unified Assessment dated April 21, 2025, was identified by clinical nurse supervisor (CNS)-B as R2's service plan. R3's Initial Unified Assessment dated April 21, 2025, was identified by CNS-B as R3's service plan.	{01650}		

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VALLEYVIEW OF NORTHFIELD	812 LINDEN STREET N NORTHFIELD, MN 55057

(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
{01650}	Continued From page 12 R10's Initial Unified Assessment dated May 22, 2025, was identified by CNS-B as R10's service plan. R2, R3, and R10's identified service plans lacked the following required content: - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan with all required content. On August 13, 2025, at 9:20 a.m., licensed assisted living director (LALD)-A stated the licensee had not developed service plans for R2, R3, and R10 with all the required content. LALD-A stated the licensee had historically completed separate service plans with all required content, but when licensee updated their electronic health record (EHR), the licensee believed the software would develop new service plans for residents. LALD-A stated the licensee's EHR did not develop the service plans with the above identified required content and were not included in the resident record. The licensee's 6.08 Service Plan policy dated August 1, 2024, indicated service plans would include the required content identified above. No further information provided.	{01650}		
{01730} SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified	{01730}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{01730}	Continued From page 13 staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing	{01730}		

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{01730}	Continued From page 14 medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individualized medication management plan (IMMP) with the required content for five of six residents (R1, R2, R3, R5, and R10). 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: On August 12, 2025, at 1:40 p.m., clinical nurse supervisor (CNS)-B stated each resident's most recent assessment included licensee's IMMP content. R1 R1 was admitted on January 24, 2019. R1's 90 Day Unified Assessment dated August 12, 2025, included a Medication Management section but lacked identification who the persons responsible for monitoring medication supplies and ensured refills were ordered in a timely basis.	{01730}		

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{01730}	Continued From page 15 R2 R2 was admitted on March 13, 2023. R2's Initial Unified Assessment dated April 21, 2025, included a Medication Management section but lacked identification who the persons responsible for monitoring medication supplies and ensured refills were ordered in a timely basis. R3 R3 was admitted on January 25, 2019. R3's Initial Unified Assessment dated April 21, 2025, included a Medication Management section but lacked identification who the persons responsible for monitoring medication supplies and ensured refills were ordered in a timely basis. R5 R5 was admitted on April 14, 2015. R5's undated, Initial Unified Assessment included a Medication Management section but lacked identification who the persons responsible for monitoring medication supplies and ensured refills were ordered in a timely basis. R10 R10 was admitted on May 20, 2025. R10's Initial Unified Assessment dated May 22, 2025, included a Medication Management section but lacked identification who the persons responsible for monitoring medication supplies and ensured refills were ordered in a timely basis.	{01730}		

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{01730}	Continued From page 16 On August 13, 2025, at 8:20 a.m., CNS-B stated the required content was included in R9's assessment, but CNS-B had not included the required content in the other residents' records. CNS-B stated the licensee recently updated their electronic health record (EHR) and they had not included the required content in the updated assessments for the identified residents. CNS-B stated each resident assessment would need to be audited and missing content be included for each resident. The licensee's 7.03 Medication Management Individualized Plan policy dated August 1, 2024, indicated each resident record would include identification of the persons responsible for monitoring refills and medication supplies. No further information provided.	{01730}		
{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	{01940}		

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{01940}	Continued From page 17 that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individualized treatment management plan (ITMP) with the required content for four of four residents (R1, R2, R3, and R9) who had a treatment. 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: R1 R1 was admitted on January 24, 2019. R1's Individualized Treatment or Therapy	{01940}		

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{01940}	Continued From page 18 Management Plan dated April 8, 2025, indicated R1 required blood glucose monitoring treatment, and resident specific requirements would be included in the electronic health record (EHR). R1's 30 Day Spanning MAR (medication administration record) dated for July 14, 2025, to August 12, 2025, was identified by clinical nurse supervisor (CNS)-B as the location the licensee would document all medications and treatments provided for residents. R1's MAR included an order for insulin aspart (a fast-acting insulin with a 10-15 minute onset from injection) to be administered four (4) times per day. R1's MAR lacked specific instructions for actions the unlicensed personnel (ULP) would take if R1's blood glucose readings were hypoglycemic (low blood glucose). R2 R2 was admitted on March 13, 2023. R2's Individualized Treatment or Therapy Management Plan dated April 8, 2025, indicated R2 required blood glucose monitoring treatment and resident specific requirements would be included in the electronic health record (EHR). R2's 30 Day Filled MAR dated August 2025, indicated R2's blood glucose was checked three times per day with the administration of R2's Humalog (insulin lispro, a fast-acting insulin with a 15 min onset from injection). The MAR lacked specific instructions for actions the ULP would take if R2 experienced hypoglycemia or hyperglycemia (elevated blood glucose) and the specific ranges for both. R3	{01940}		

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{01940}	Continued From page 19 R3 was admitted on January 25, 2019. R3's Individualized Treatment or Therapy Management Plan dated April 8, 2025, indicated R3 required blood glucose monitoring treatment and resident specific requirements would be included in the electronic health record (EHR). The plan read under, "Notes: Notify provider is glucose > (greater than) 350 or < (less than) 70." R3's 30 Day Filled MAR dated August 2025, indicated R3 had their blood glucose checked two times per day but lacked the specific ranges identified above on R3's treatment plan for the ULP to reference when a blood glucose check was completed. R9 R9 was admitted on August 13, 2009. R9's Individualized Treatment or Therapy Management Plan dated June 10, 2009, indicated R9 required treatment services for compression garments (thromboembolic deterrent stockings or commonly called TED hose). R9's 30 Day Filled MAR dated August 2025, indicated R9 was assisted with their TED hose being donned (put on) and doffed (taken off) every morning and evening respectively. The MAR lacked indications and instructions for actions the ULP would take if a problem arose or when the TED hose should not be donned. On August 12, 2025, at 3:00 p.m., CNS-B stated each resident record should have the instructions, indications, and ranges on the MAR so the ULPs would have access to the specific	{01940}		

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{01940}	Continued From page 20 instructions for each resident. CNS-B stated the licensee trained the ULPs on standard ranges, but the licensee did not obtain specific ranges for the blood glucose readings for each resident with blood glucose checks. CNS-B stated the licensee trained the ULPs on when TED hose should not be applied and to contact the nurse, but did not include those instructions in R9's record. The licensee's 7.05 Treatment & Therapy Management Plan dated August 1, 2024, indicated each resident record would include resident specific instructions for each treatment administered by the licensee. No further information provided.	{01940}		
{02310} SS=I	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 four of four residents (R1, R3, R9, and R10) with bed rails (commonly called side rails). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident),	{02310}		

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{02310}	Continued From page 21 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 August 12, 2025, at 2:00 p.m., the surveyor requested licensed assisted living director (LALD)-A provide a tour of resident rooms who had bed rails. The surveyor observed R1, R3, and R10's rooms and noted R1 and R10 had consumer bed rails, and R3 had hospital-style bed rails. The bed rails were securely installed to the bed frames of each resident's bed. R1 R1 was admitted on January 24, 2019. R1's undated, Side Rail assessment for consumer style side rails lacked documentation licensee ensure R1's bed rails were not recalled on the Consumer Product Safety Commission (CSPC) website. R3 R3 was admitted on January 25, 2019. R3's Initial Side Rail assessment dated August 12, 2025, for hospital-style bed rails lacked zone measurements as required by the United States Food and Drug Administration (FDA) to prevent entrapment and death. R9 R9 was admitted on August 13, 2009. R9's Side Rail assessment dated June 4, 2025,	{02310}		

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{02310}	Continued From page 22 lacked documentation the licensee ensured R9's consumer bed rails were not recalled on the CPSC website. R10 R10 was admitted on May 20, 2025. R10's undated, Side Rail assessment for consumer style side rails lacked documentation licensee ensure R10's bed rails were not recalled on the CPSC website. On August 12, 2025, at 2:00 p.m., LALD-A stated the licensee's side rail assessments lacked a section for documentation related to checking for recalls on the CPSC website. LALD-A stated the licensee would need to add the brand and model numbers to the assessment to ensure recalls are checked with each assessment. LALD-A stated they were not sure why R3's measurements were not documented as the licensee was aware of the requirement for measurements. LALD-A stated the licensee measured all required zones, but the person who obtained the measurements must have not entered them into R3's record. The Assisted Living: Resources and Frequently Asked Questions (FAQs) - MN (Minnesota) Department of Health Consumer bed rails website last updated July 1, 2025, and accessed August 15, 2025, indicated the licensee should review the CSPC website with each resident ongoing assessment and document if the bed rails had been recalled. 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	{02310}		

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{02310}	Continued From page 23 status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, 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 licensee's 6.28 Side rails policy dated August 1, 2024, indicated the licensee would measure and document the FDA identified zones when hospital-style bed rails were in use, but the policy lacked identification for checking the CSPC website for recalls when consumer bed rails were in use. No further information provided.	{02310}		

Electronically Delivered

March 27, 2025

Licensee
Valleyview Of Northfield
812 Linden Street North
Northfield, MN 55057

RE: Project Number(s) SL30330016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 20, 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.

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

0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00
2320 - 144g.91 Subd. 4 (b) - Appropriate Care And Services - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,500.00**. 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.

INFORMAL CONFERENCE
In accordance with Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Valleyview Of Northfield. Please contact Jodi Johnson at 507-344-2730 on or before Tuesday, April 1, 2025, to schedule the conference call.

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

JMD

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VALLEYVIEW OF NORTHFIELD	812 LINDEN STREET N NORTHFIELD, MN 55057

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0 000	Initial Comments 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: SL30330016-0 On February 18, 2025, through February 20, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 35 residents; 35 receiving services under the Assisted Living Facility license. 2310: An immediate correction order was issued on February 19, 2025, at a level 3/Widespread (I). The licensee took action on February 19, 2025; however, the scope and level remains at I. 2320: An immediate correction order was issued on February 19, 2025, at a level 3/Widespread (I). The licensee took action on February 19, 2025; however, the scope and level remains at I.	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.	
0 420 SS=F	144G.40 Subdivision 1 Responsibility for housing and services	0 420		

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	30330	A. BUILDING: _____ B. WING _____	02/20/2025

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0 420	Continued From page 1 The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide sufficient housing and service-related management, control, and operation of the facility. 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the survey from February 18, 2025, through February 20, 2025, the surveyor completed observations, interviews, and record reviews for the licensee providing assisted living services to residents. The licensee had an assisted living license, effective September 1, 2024. The licensee's renewal "Application for Assisted	0 420		

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0 420	Continued From page 2 Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified an affirmative checkmark next to the statement, "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659, governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." Another checkmark was noted on the statement, "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." Page six was electronically signed by the owner/authorized agent on May 25, 2022. As a result of this survey, the following orders were issued under 0550, 0630, 0640, 0660, 0680, 0730, 0775, 0810, 1060, 1370, 1380, 1440, 1500, 1530, 1620, 1640, 1650, 1710, 1730, 1750, 1760, 1770, 1790, 1820, 1830, 1910, 1940, 1960, 1970, 2310, and 2320 which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 420		

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0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts	0 480		

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0 480	Continued From page 4 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 19, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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

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0 550	Continued From page 6 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 February 18, 2025, at 10:00 a.m. during the facility tour, the surveyor did not observe any signage or information posted regarding the grievance procedure, and the name, telephone number and email contact information for individuals who were responsible for handling resident grievances. On February 18, 2025, at 11:27 a.m., licensed assisted living director (LALD)-A stated the grievance procedure had been posted on the bulletin board in the activity room; however, it was no longer posted. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes	0 630		

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0 630	Continued From page 7 self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of three residents (R2 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 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: R2 R2 was admitted on March 13, 2023, with diagnoses that included diabetes and schizoaffective disorder (mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania and a milder form of mania called hypomania). R2's care plan (used as the service plan) dated December 17, 2024, indicated R2 received services to include housekeeping, laundry, bathing assist, cues/reminders to complete activities of daily living, grooming, blood sugar monitoring and medication administration. On February 19, 2025, at 7:35 a.m., the surveyor	0 630		

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0 630	Continued From page 8 observed unlicensed personnel (ULP)-D administer medications to R2. R2's IAPP dated December 30, 2024, indicated R2 was not at risk to be abused (physically, verbally, financially and/or sexually) by others. The licensee failed to recognize R2 was a vulnerable adult and was susceptible to abuse/neglect by others. Furthermore, the licensee failed to implement interventions to minimize his abuse by others including other vulnerable adults. R3 R3 was admitted on January 25, 2023, with diagnosis that included diabetes. R3's care plan (used as the service plan) dated February 19, 2025, indicated R3 received services to include housekeeping, laundry, bathing setup, documentation of blood glucose checks, and medication administration. On February 18, 2025, at 12:11 p.m., the surveyor observed ULP-D administer medications to R3. R3's IAPP dated February 13, 2023, indicated R3 was not at risk to be abused (physically, verbally, financially and/or sexually) by others. The licensee failed to recognize R2 was a vulnerable adult and was susceptible to abuse/neglect by others. Furthermore, the licensee failed to implement interventions to minimize her abuse by others including other vulnerable adults. On February 20, 2025, at 10:56 a.m., clinical nurse supervisor (CNS)-B stated R2 and R3 were considered vulnerable adults and their IAPP should have indicated they were at risk to be	0 630		

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0 630	Continued From page 9 abused. The licensee's Individual Abuse Prevention Plan policy dated August 1, 2024, indicated the license would develop and implement an individual abuse prevention plan for each vulnerable adult. 1. The plan will contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including: a. Other vulnerable adults b. The person's risk of abusing other vulnerable adults, and c. Statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults 2. for purposes of the abuse prevention plan, abuse includes self-abuse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language.	0 640		

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0 640	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of residents). The findings include: On February 18, 2025, at 10:00 a.m. during the facility tour, the surveyor did not observe any signage or information posted regarding the 911 emergency number. On February 18, 2025, at 11:28 a.m., licensed assisted living director (LALD)-A stated they did not have the 911 emergency number posted. LALD-A further stated she was not aware of this requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control	0 660		

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0 660	Continued From page 11 (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) by failing to complete a two-step TST (tuberculin skin test) or other evidence of tuberculosis (TB) screening such as a blood test for one of two employees (unlicensed personnel (ULP)-C). 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:	0 660		

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0 660	Continued From page 12 ULP-C was hired on February 24, 2024, to provide direct care and services to the facility's residents. ULP-C's employee record contained a negative one step TST dated February 22, 2024; however, ULP-C's employee record lacked evidence of a second step TST. On February 20, 2025, at 10:29 a.m., clinical nurse supervisor (CNS)-B stated ULP-C had not completed the second step TST as required. The licensee's Tuberculin Skin Testing Protocol policy, undated, indicated all employees would have a two-step TST. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and	0 680		

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0 680	Continued From page 13 (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an all-hazards risk assessment emergency preparedness (EP) program and plan to include Appendix Z required elements and failed to post the plan prominently. 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 the residents). The findings include: The licensee undated, Emergency Procedure Binder lacked the following required information according to Emergency Preparedness: Appendix Z: - establish/maintain a comprehensive emergency plan (EP) which describes the facility's approach	0 680		

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0 680	Continued From page 14 to meeting health/safety/security needs of staff/residents addressing how they would coordinate with other, health care facilities (HCF), as well as community on a whole during emergency or disaster (natural, man-made, facility, etc.) and be reviewed/updated annually; - risk assessment which considered hazards like care related emergencies, cyber-attacks, normal supply of essential resources and medical supplies, should consider duration of interruptions, consider emerging infectious diseases (EIDs); - document risk assessment for an all-hazards approach, including EIDs as applicable, categorize the various probable risks by likelihood of occurrence, develop strategies for addressing facility and community-based risks (evacuation plans, staffing surges/shortages, back-up plans); - identification of at-risk population needs like maintaining independence, communication, transportation, supervision, medical care; and qualified person authorized in writing to act in the absence of the administrator; - a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - policy and procedure based on the EP risk assessment and communication plan; - policy and procedure addressing whether evacuated or shelter in place for staff/residents for food, water, medical supplies, pharmaceutical supplies; - policy and procedure addressing alternate sources of energy to maintain temperatures to protect resident health/safety, safe and sanitary storage of provisions emergency lighting and sewage and waste disposal; - 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	0 680		

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0 680	Continued From page 15 relocated, the facility must document the specific name/location of the receiving facility or other location; - policy and procedure addressing safe evacuation form facility, including care and treatment needs of evacuees; staff responsibilities; primary/alternate communication means with external sources of assistance; - policy and procedure to shelter in place for residents, staff, and volunteers who remain in the facility; - policy and procedure addressing system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - policy and procedure addressing use of volunteers, including the process/role for integration; - policy and procedures addressing development of arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents; - policy and procedure addressing the role of facility under waiver declared by the Secretary in accordance with section 1135 of the ACT; - develop a written communication plan; - communication plan which includes names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, volunteers; - communication plan which includes contact information for Federal, State, tribal, regional, and local EP staff; State Licensing and Certification Agency; and other sources of assistance; - communication plan which includes alternate means of communication with facility staff and Federal, State, tribal, regional, and local emergency management agencies; - communication plan which includes method for	0 680		

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0 680	Continued From page 16 sharing information and medical documentation for residents under the facility's care, as necessary, with other health care personnel to maintain continuity of care; means, in event of evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii); means of providing information about general condition/location of residents under facility's care as permitted under 45 CFR 164.510(b)(4); - communication plan which includes means to providing information about the facility occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the incident command center, or designee; and - communication plan which includes method for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families/representatives; - develop and maintain an EP training and testing program; - training program which includes initial training in EP policy and procedure to all new and existing staff, individuals providing services under arrangement, volunteers consistent with their expected role; provide EP training at least annually; maintain documentation of all EP training; demonstrate staff knowledge of EP; - conduct exercises to test EP at least twice per year, including unannounced staff drills using EP, including participating in an annual full-scale exercise community based or annual individual facility based functional exercise or if facility experiences an actual emergency requiring evacuation of plan, facility is exempt from engaging in its next required full scale exercise; conduct an additional annual exercise that may include a second full scale exercise community based or an individual; facility based functional exercise or mock disaster drill or table top exercise.	0 680		

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0 680	Continued From page 17 On February 20, 2025, at 11:55 a.m., licensed assisted living director (LALD)-A stated the licensee's EP plan and Appendix Z lacked the required content as listed above and was something she was working on. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the	0 730		

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0 730	Continued From page 18 resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to include the required content in a discharge summary for one of one discharged resident (R4). 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:	0 730		

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0 730	Continued From page 19 R4 was admitted to the licensee on November 19, 2018, and discharged to another facility on February 6, 2025. R4's record lacked a discharge summary to include the following required content: -a summary of the resident's stay that includes diagnoses, course of illnesses, allergies, treatments and therapies and pertinent lab, radiology, and consultation results; -a final summary of the resident's status from the latest assessment or review under Minnesota Statues, section 144G.70, if applicable, that includes the resident status, including baseline and current mental, behavioral, and functional status; -a reconciliation of all predischarge medications with the resident's post discharge prescribed and over-the-counter medications; and -a post discharge plan that is developed with the resident and, with the resident's consent, the resident's representatives, which will help the resident adjust to a new living environment. The post discharge plan must indicate where the resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any post discharge medical and nonmedical services the resident will need. On February 18, 2025, at 2:21 p.m., clinical nurse supervisor (CNS)-B stated she was not aware of the required content for the discharge summary. CNS-B stated when a resident discharged, she would document the discharge in a progress note; however, the note did not include the required content as listed above. The licensee's Resident Discharge Summary policy dated June 2021, indicated the discharge	0 730		

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0 730	Continued From page 20 summary would include the following: -a summary of the resident's stay that included diagnoses, courses of illnesses, allergies, treatments, ad therapies, ad pertinent lab, radiology, and consultation results -a final summary of the resident's status from the latest assessment or review, if applicable, which included the resident status, including baseline and current mental, behavioral, and functional status -a reconciliation of all pre-discharge medications with the resident's post-discharge prescribed ad over-the-counter medications -a post-discharge care plan that was developed with the resident and, with the resident's consent, the resident's representatives, which will help the resident adjust to a new living environment. The post-discharge care plan will indicate where the resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any post-discharge medication and nonmedical services the resident will need. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
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 maintain fire protection equipment and to	0 775		

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0 775	Continued From page 21 provide a facility with clear access to egress windows in compliance with Minnesota State Fire Code under Minnesota Rules Chapter 7511. This had the potential to affect residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 19, 2025, from approximately 12:22 p.m. to 1:45 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-A and director of maintenance (DM)-F and observed the following deficient conditions: The surveyor requested DM-F to test emergency light fixtures throughout the facility. Several emergency light fixtures failed to illuminate upon testing. When tested, the emergency light fixtures across from the nursing station, within the activities room, near resident room 100, near resident room 128, and near resident room 101 were found not to be functional. The surveyor explained that supplied fire safety equipment including emergency lighting must be maintained in proper working order and in operable condition and LALD-A and DM-F stated that they understood the requirements. The illuminated exit sign near the front entry door was tested by DM-F and failed to illuminate when tested. The emergency exit sign was not	0 775		

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0 775	Continued From page 22 maintained in a functional condition and should remain illuminated when tested so that they will maintain illumination in the incidence of power loss in the building. A marked emergency exit door near the LALD's office led to an area that contained a significant accumulation of snow and was not maintained with a clear path of egress. The emergency exit should be maintained free of obstruction, such as snow and ice, to provide clear path out of building. LALD-A and DM-F acknowledged requirements and indicated they would maintain the emergency exit free of snow. The egress window in resident room 130 was obstructed by a stack of boxes full of clothes which were stored in front of the window, impeding access to the window. The egress window in resident room 117 was obstructed by furniture and stored materials which were stored in front of the window, impeding access to the window. The surveyor explained requirements to keep egress windows free of obstruction so that they may be readily accessed and utilized during an emergency. The smoking room was equipped with a fire extinguisher in a fire extinguisher cabinet that had a scored plexiglass window. The cabinet was locked and not equipped with a tool such as a breaker bar or hammer to break through the window in case of emergency to access extinguisher. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		

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0 810	Continued From page 23	0 810		
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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire	0 810		

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0 810	Continued From page 24 safety and evacuation plan (FSEP) with the required staff training, resident training, and fire drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or 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 February 19, 2025, at approximately 1:45 p.m. licensed assisted living director (LALD)-A and director of maintenance (DM)-F. provided documentation on the fire safety and evacuation plan (FSEP). The licensee's FSEP failed to include the following: The FSEP did not include procedures for resident movement, evacuation or relocation during a fire or similar emergency. The was no documentation provided or available to document resident evacuation procedures for the facility. LALD-A stated that a written plan has not been included in the FSEP, but that it will be developed for future use. The FSEP did not include documentation of employee training on the FSEP. LALD-A provided information on annual Educare training but acknowledged that FSEP training was not being conducted or recorded but indicated that such training would be implemented and recorded. FSEP training is required for all	0 810		

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0 810	Continued From page 25 employees upon hire and at least twice a year thereafter. The FSEP did not include documentation of fire drills performed at the facility. Fire drills are required at least twice a year per shift and at least once every other month. The FSEP did not include any documentation on resident training on the FSEP. Residents who are capable of assisting in their evacuation should be offered training at least once per year. During interview on February 19, 2025, the surveyor explained the requirements for frequency of drills, employee training, resident drills and documentation to LALD-A indicated that they understood the requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office	01060		

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01060	Continued From page 26 of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01060		

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01060	Continued From page 27 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: R2 was admitted on March 13, 2023, with diagnoses that included diabetes and schizoaffective disorder (mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania and a milder form of mania called hypomania). R2's care plan also used as the service plan dated December 17, 2024, indicated R2 received services to include housekeeping, laundry, bathing assist, cues/reminders to complete activities of daily living, grooming, blood sugar monitoring and medication administration. R2's progress notes dated July 3, 2024, indicated the following: "Nursing received a call from the wound care center. He (R2) had an emergency appointment with them on Monday, d/t (due to) a change in condition of his wound. They did some imaging, and he was to have an appointment with them today. They called and informed nursing they had some concerns with the images that were taken, and he should be seen in the ER (emergency room) immediately. They were going to cancel his appointment for today and possibly see him there. Resident was informed and it took some persuading to get him to go in. He also reported some testicle pain and asked nurse to look at area. Nothing seemed abnormal but	01060		

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01060	Continued From page 28 nursing told him to report at ER while he was there". R2's History and Physical Report dated September 13, 2024, indicated R2 was hospitalized July 3, 2024, through July 18, 2024. R2 discharged from the hospital to a skilled nursing facility for short term rehabilitation. R2 returned to the licensee on September 16, 2024 (75 days later). R2's record lacked a written notice that contains, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R2's record lacked notification to the Office of Ombudsman for Long-Term Care the resident had been relocated and had not returned to the facility within four days. On February 20, 2025, at 10:45 a.m., clinical nurse supervisor (CNS)-B stated R2's record lacked evidence a written notice related to R2's emergency relocation had been completed and provided, and further lacked notification to the	01060		

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01060	Continued From page 29 Office of Ombudsman for Long-Term Care that the resident had been relocated and had not returned to the facility within four days. CNS-B and licensed assisted living director (LALD)-A further stated they were not aware of this requirement. The licensee's Emergency Relocation policy dated August 1, 2022, indicated the following: 1. In the event of an emergency relocation, the licensee will provide a written notice that contains, at minimum: a. The reason for relocation b. The name and contact information for the location to which the resident has been relocated and any new service provider c. Contact information for the Office of Ombudsman for Long-Term Care d. If known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known, and e. A statement, that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal. 2. The facility will provide contact information for the agency to which the resident may submit an appeal. 3. The notice required will be delivered as soon as practicable to: a. The resident, legal representative, and designated representative b. For residents who receive home and community-based waiver services, the resident's case manager and c. The Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days 4. Following an emergency relocation, a facility's refusal to provide housing or services constitutes	01060		

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01060	Continued From page 30 a termination and triggers the contract termination process. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01060		
01370 SS=F	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; (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	01370		

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01370	Continued From page 31 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 interview and record review, the licensee failed to ensure training and competency was completed for two of two employees (unlicensed personnel (ULP)-C and ULP-D) 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 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-C ULP-C was hired on February 24, 2024, to provide direct care and services to the facility's residents. ULP-C's employee record lacked evidence of competency evaluation for the following topics: - appropriate and safe techniques in personal hygiene and grooming, including:	01370		

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01370	Continued From page 32 - hair care and bathing - care of teeth, gums and oral prosthetic devices - care and use of hearing aids - dressing and assisting with toileting - standby assistance techniques and how to perform them ULP-D ULP-D was hired on February 10, 2022, to provide direct care and services to the facility's residents. ULP-D's employee record lacked evidence of competency evaluation for the following topics: - appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing - care of teeth, gums and oral prosthetic devices - care and use of hearing aids - dressing and assisting with toileting - standby assistance techniques and how to perform them On February 19, 2025, at 1:17 p.m., clinical nurse supervisor (CNS)-B stated ULP-C and ULP-D were trained and competent in all the areas listed above, but their record lacked evidence of competencies. CNS-B further stated the licensee did not have documentation of competencies for any of the ULP. The licensee's Competency Training Evaluations policy dated August 1, 2024, indicated training ad competency evaluations for all ULP's would include the following: e. appropriate and safe techniques in personal hygiene and grooming, including:	01370		

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01370	Continued From page 33 i. hair care and bathing ii. care of teeth, gums, and oral prosthetic devices iii. care and use of hearing aids iv. dressing and assisting with toileting g. standby assistance techniques and how to perform them No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency was completed for two of two employees	01380		

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01380	Continued From page 34 (unlicensed personnel (ULP)-C and ULP-D) 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 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-C ULP-C was hired on February 24, 2024, to provide direct care and services to the facility's residents. ULP-C's employee record lacked evidence of competency evaluation for the following topics: - reading and recording temperature, pulse, and respirations of the resident - safe transfer techniques and ambulation - range of motioning and positioning - administering medications or treatments as required ULP-D ULP-D was hired on February 10, 2022, to provide direct care and services to the facility's residents. ULP-D's employee record lacked evidence of competency evaluation for the following topics: - reading and recording temperature, pulse, and respirations of the resident - safe transfer techniques and ambulation - range of motioning and positioning	01380		

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01380	Continued From page 35 - administering medications or treatments as required On February 19, 2025, at 1:17 p.m., clinical nurse supervisor (CNS)-B stated ULP-C and ULP-D were trained and competent in all the areas listed above, but their record lacked evidence of competencies. CNS-B further stated the licensee did not have documentation of competencies for any of the ULP. The licensee's Competency Training Evaluations policy dated August 1, 2024, indicated training ad competency evaluations for all ULP's would include the following: c. Reading and recording temperature, pulse, and respirations of the resident e. Safe transfer techniques and ambulation f. Range of motioning and positioning g. Administering medications or treatments as required No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff	01440		

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01440	Continued From page 36 performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for two of two unlicensed personnel (ULP-C ad 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 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-C ULP-C was hired on February 24, 2024, to provide direct care and services to the facility's	01440		

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01440	Continued From page 37 residents. On February 18, 2025, at 10:58 a.m., the surveyor observed ULP-C administer medications to R1. ULP-C's employee record lacked documentation of a RN supervision ULP-C performing delegated tasks within 30 days of beginning work with the licensee. ULP-D ULP-D was hired on February 10, 2022, to provide direct care and services to the facility's residents. On February 18, 2025, at 12:11 p.m., the surveyor observed ULP-D administer medications to R3. ULP-D's record contained a 30-Day Performance Review document dated April 12, 2023. However, the document did not include evidence of a RN supervision of ULP-D performing delegated tasks. On February 19, 2025, at 1:19 p.m., clinical nurse supervisor (CNS)-B stated she would do a performance check in with the ULP within 30 days of their hire date; however, she did not supervise the ULP perform delegated tasks at that time. The licensee's Supervision of Staff-Delegated Services policy dated August 1, 2024, indicated direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the licensee and first performs the delegated tasks for residents and thereafter as	01440		

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01440	Continued From page 38 needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
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	01500		

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01500	Continued From page 39 procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on 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	01500		

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01500	Continued From page 40 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-D was hired on February 10, 2022, to provide direct care and services to the facility's residents. On February 18, 2025, at 12:11 p.m., the surveyor observed ULP-D administer medications to R3. ULP-D's employee record lacked evidence the employee had successfully completed annual training as required, to include the following: - effective approaches to use to problem solve when working with resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures On February 19, 2025, at 1:15 p.m., licensed assisted living director (LALD)-A stated ULP-D's record lacked the above training as required. The licensee's Annual Required Staff Training policy dated August 1, 2024, indicated the following training elements must be included every 12 months to all staff wo performs direct care services: 4. Effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with	01500		

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01500	Continued From page 41 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 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two	01530		

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01530	Continued From page 42 hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of two employees (unlicensed personnel (ULP)-C and ULP-D) received the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: The licensee provided services under an Assisted Living Facility license. ULP-C ULP-C was hired on February 24, 2024, to provide direct care and services to the facility's residents. ULP-C's employee record contained evidence the employee received three and a half hours of dementia care training, not the required eight hours of training within 160 working hours of the employment start date. ULP-D ULP-D was hired on February 10, 2022, to provide direct care and services to the facility's	01530		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEYVIEW OF NORTHFIELD	812 LINDEN STREET N NORTHFIELD, MN 55057

(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
01530	Continued From page 43 residents. ULP-D's employee record contained evidence the employee received four and a half hours of dementia care training, not the required eight hours of training within 160 working hours of the employment start date. ULP-D's record lacked evidence of annual dementia care training for the year 2023. ULP-D's record contained evidence the employee received forty-five minutes of annual dementia training for the year 2024, not the required two hours. On February 20, 2025, at 10:29 a.m., licensed assisted living director (LALD)-A reviewed ULP-C and ULP-D's training record and stated they had not completed the required dementia care training as listed above. LALD-A stated all employees were assigned four and a half hours of dementia care training upon hire, not the required eight hours. LALD-A stated the required dementia care training content was met within the four and a half hours of training and thought that was sufficient. LALD-A stated the licensee was behind on annual training. The licensee's Dementia Training policy dated August 1, 2024, indicated the following: -direct care employees will complete eight (8) hours of initial training within 160 hours of the start date -all staff will complete two (2) hours of additional training for each 12 months of work thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		

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01620	Continued From page 44	01620		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted timely ongoing nursing assessments for three of three residents (R1, R2, 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	01620		

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01620	Continued From page 45 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: R1 R1 was admitted on January 24, 2019, with diagnoses that included diabetes. R1's care plan (used as the service plan) dated November 12, 2024, indicated R1 received assistance with housekeeping, laundry, meals, daily blood pressure checks, blood glucose checks three times a day and medication administration. R1's ongoing nursing assessments were requested. Assessments dated March 4, 2024, July 8, 2024, and November 12, 2024, were provided. The July 8, 2024, assessment was completed 126 days after the date of the previous assessment, and the November 12, 2024, assessment was completed 127 days after the date of the previous assessment, thus exceeding 90 calendar days. R1's record lacked an ongoing nurse assessment which was due by February 10, 2025. R2 R2 was admitted on March 13, 2023, with diagnoses that included diabetes and schizoaffective disorder (mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions,	01620		

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01620	Continued From page 46 and mood disorder symptoms, such as depression, mania and a milder form of mania called hypomania). R2's care plan (used as the service plan) dated December 17, 2024, indicated R2 received services to include housekeeping, laundry, bathing assist, cues/reminders to complete activities of daily living, grooming, blood sugar monitoring and medication administration. R2's ongoing nursing assessments were requested. An assessment dated September 17, 2024, was provided. R2's record lacked any additional ongoing nurse assessments since September 17, 2024. R3 R3 was admitted on January 25, 2023, with diagnosis that included diabetes. R3's care plan (used as the service plan) dated February 19, 2025, indicated R3 received services to include housekeeping, laundry, bathing setup, documentation of blood glucose checks, and medication administration. R3's ongoing nursing assessments were requested. Assessments dated January 4, 2024, May 1, 2024, and July 23, 2024, were provided. The May 1, 2024, assessment was completed 118 days after the date of the previous assessment, thus exceeding 90 calendar days. R3's last ongoing nurse assessment was dated July 23, 2024. R3's record lacked an ongoing nurse assessment which was due by October 21, 2024. On February 19, 2025, at 1:00 p.m., clinical nurse	01620		

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01620	Continued From page 47 supervisor (CNS)-B stated R1, R2, and R3's assessments were not completed within the required timeframe. CNS-B stated she was behind on nurse assessments. The licensee's Assessments, Reviews and Monitoring policy dated August 1, 2024, indicated resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan.	01640		

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01640	Continued From page 48 (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was signed and revised to reflect the current services provided for three of three residents (R1, R2, 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 January 24, 2019, with diagnoses that included diabetes. On February 18, 2025, at 10:58 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R1. R1's care plan (used as the service plan) dated November 12, 2024, indicated R1 received assistance with housekeeping, laundry, meals, daily blood pressure checks, blood glucose checks three times a day and medication	01640		

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01640	Continued From page 49 administration. R1's care plan was not signed by the licensee or R1. R2 R2 was admitted on March 13, 2023, with diagnoses that included diabetes and schizoaffective disorder (mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania and a milder form of mania called hypomania). On February 19, 2025, at 7:35 a.m., the surveyor observed ULP-D administer medications to R2. R2's care plan (used as the service plan) dated December 17, 2024, indicated R2 received services to include housekeeping, laundry, bathing assist, cues/reminders to complete activities of daily living, grooming, blood sugar monitoring and medication administration. R2's prescriber orders dated October 21, 2024, included: -amlodipine 10 milligram (mg); take one tablet by mouth daily, check blood pressure, *hold for SBP less than 120* R2's record lacked documentation of blood pressure checks. R2's care plan did not include daily blood pressure checks and was not signed by the licensee or R2. R3 R3 was admitted on January 25, 2023, with	01640		

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01640	Continued From page 50 diagnosis that included diabetes. On February 18, 2025, at 12:11 p.m., the surveyor observed ULP-D administer medications to R3. R3's care plan (used as the service plan) dated February 19, 2025, indicated R3 received services to include housekeeping, laundry, bathing setup, documentation of blood glucose checks, and medication administration. R3's care plan was not signed by the licensee or R3. On February 18, 2025, at 2:09 p.m., clinical nurse supervisor (CNS)-B stated R2's care plan should have included daily blood pressure checks. CNS-B stated none of the residents would have a signed care plan as she was not aware that she needed to review the care plan with the resident and/or resident representative and have them signed. On February 20, 2025, at 10:11 a.m., licensed assisted living director (LALD)-A stated in the past the licensee had a second document for the resident to sign regarding the care plan; however, the licensee was not currently utilizing this document. The licensee's Service Plan policy dated August 1, 2024, indicated the service plan and any revisions shall include a signature or other authentication by [licensee] and by the resident, or resident's representative, documenting agreement on the services to be provided. No further information was provided.	01640		

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01640	Continued From page 51 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included	01650		

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01650	Continued From page 52 all required content for three of three residents (R1, R2, 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) 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 January 24, 2019, with diagnoses that included diabetes. R1's care plan (used as the service plan) dated November 12, 2024, indicated R1 received assistance with housekeeping, laundry, meals, daily blood pressure checks, blood glucose checks three times a day and medication administration. R1's service plan lacked the following content: - the fees for services - the schedule and methods of monitoring assessment of the resident; - the schedule and methods of monitoring the staff providing services; and - a contingency plan that includes: the action to be taken if the scheduled service cannot be provided; information and a method to contact the facility; the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of an information as to who has authority to sign for the resident in and	01650		

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01650	Continued From page 53 emergency; and the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. R2 R2 was admitted on March 13, 2023, with diagnoses that included diabetes and schizoaffective disorder (mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania and a milder form of mania called hypomania). R2's care plan (used as the service plan) dated December 17, 2024, indicated R2 received services to include housekeeping, laundry, bathing assist, cues/reminders to complete activities of daily living, grooming, blood sugar monitoring and medication administration. R2's service plan lacked the following content: - the fees for services - the schedule and methods of monitoring assessment of the resident; - the schedule and methods of monitoring the staff providing services; and - a contingency plan that includes: the action to be taken if the scheduled service cannot be provided; information and a method to contact the facility; the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of an information as to who has authority to sign for the resident in and emergency; and the circumstances in which emergency medical services are not to be	01650		

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01650	Continued From page 54 summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. R3 R3 was admitted on January 25, 2023, with diagnosis that included diabetes. R3's care plan (used as the service plan) dated February 19, 2025, indicated R3 received services to include housekeeping, laundry, bathing setup, documentation of blood glucose checks, and medication administration. R3's service plan lacked the following content: - the fees for services - the schedule and methods of monitoring assessment of the resident; - the schedule and methods of monitoring the staff providing services; and - a contingency plan that includes: the action to be taken if the scheduled service cannot be provided; information and a method to contact the facility; the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of an information as to who has authority to sign for the resident in and emergency; and the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On February 20, 2025, at 9:35 a.m., clinical nurse supervisor (CNS)-B stated R1, R2, and R3's service plan did not include the required content as listed above. CNS-B further stated the same service plan was used for all residents.	01650		

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01650	Continued From page 55 The licensee's Service Plan policy dated August 1, 2024, indicated the service plan would include following: a. A description of the services that are to be provided based on the most recent assessment and resident preferences b. Fees for services to be provided c. The frequency of each service to be provided based on the most recent assessment and resident preferences d. An identification of staff or categories of staff who will be providing the services e. A schedule and method for the next planned assessment or monitoring f. A schedule and method for the next planned monitoring of staff providing services g. A contingency plan that includes: a. Acton's the facility will take if scheduled services cannot be provided b. Information regarding how the resident can contact the facility c. The names and contact information the resident wishes, if any, to have notified in an emergency or if there is a significant adverse change in the resident's condition d. Identification and contact information of who the resident has authorized, if any, to sign for the resident in an emergency e. How the facility will support documented resident health care directive decisions, if any-including circumstances when emergency medication services are not to be summoned No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		

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01710	Continued From page 56	01710		
01710 SS=F	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management reassessment at least annually for three of three residents (R1, R2, and R3) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on February 18, 2025, at 9:21 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to the licensee's residents. R1 R1 was admitted on January 24, 2019, with diagnoses that included diabetes.	01710		

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01710	Continued From page 57 On February 18, 2025, at 10:58 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R1. R1's care plan (used as the service plan) dated November 12, 2024, indicated R1 received assistance with medication administration. R1's record included a Medication Management Assessment dated September 20, 2022. R1's record lacked an annual face-to-face medication reassessment to include an identification and review of all medications the resident was known to be taking including, a review of the indications for use, side effects, contraindications, allergic or adverse reactions, and interventions needed in management of medications to prevent diversion. R2 R2 was admitted on March 13, 2023, with diagnoses that included diabetes and schizoaffective disorder (mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania and a milder form of mania called hypomania). On February 19, 2025, at 7:35 a.m., the surveyor observed ULP-D administer medications to R2. R2's care plan (used as the service plan) dated December 17, 2024, indicated R2 received assistance with medication administration. R2's record included a Medication Management Assessment dated March 20, 2023.	01710		

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01710	Continued From page 58 R2's record lacked an annual face-to-face medication reassessment to include an identification and review of all medications the resident was known to be taking including, a review of the indications for use, side effects, contraindications, allergic or adverse reactions, and interventions needed in management of medications to prevent diversion. R3 R3 was admitted on January 25, 2023, with diagnosis that included diabetes. On February 18, 2025, at 12:11 p.m., the surveyor observed ULP-D administer medications to R3. R3's care plan (used as the service plan) dated February 19, 2025, indicated R3 received assistance with medication administration. R3's record included a Medication Management Assessment dated February 13, 2023. R3's record lacked an annual face-to-face medication reassessment to include an identification and review of all medications the resident was known to be taking including, a review of the indications for use, side effects, contraindications, allergic or adverse reactions, and interventions needed in management of medications to prevent diversion. On February 20, 2025, at 10:40 a.m., CNS-B stated R1, R2, and R3's medication management assessments had not been reassessed as required. CNS-B stated she was not aware that reassessment was required as needed, and at minimum, annually.	01710		

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01710	Continued From page 59 The licensee's Medication Management - Assessment, Monitoring & Reassessment policy dated August 1, 2021, indicated "[Licensee] will, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber conduct an assessment to determine what medication management services will be provided and how the services will be provided. Also, included "1) The assessment must be conducted face-to-face with the resident by an RN. 2) The assessment must include an identification and review of all medications the resident is known to be taking. 3) The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. 4) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. ** "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. 5) [Licensee] will monitor and reassess the resident's medication management services as needed when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		

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01730	Continued From page 60	01730		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes.	01730		

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01730	Continued From page 61 (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with the required content for three of three residents (R1, R2, 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 January 24, 2019, with diagnoses that included diabetes. On February 18, 2025, at 10:58 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R1. R1's care plan (used as the service plan) dated November 12, 2024, indicated R1 received assistance with medication administration. R1's Medication Administration Record (MAR) dated February 2025, included the following medications:	01730		

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01730	Continued From page 62 -atorvastatin 20 milligram (mg); take one tablet by mouth every night at bedtime (cholesterol); prescriber order dated June 2, 2024. -basaglar injection 100 units; inject 40 units subcutaneously every night at bedtime (insulin); prescriber order dated March 26, 2024. -cetirizine 10 mg; take one tablet by mouth daily (allergies); prescriber order dated June 29, 2024. -clonazepam 0.5 mg; take one half tablet by mouth at bedtime (anxiety); prescriber order dated August 25, 2024. -ferrous sulfate 45 mg; take one tablet by mouth daily (supplement); prescriber order dated June 29, 2024. -Novolog 100 units/milliliter (ml); inject 12 units subcutaneously three times daily before meals (insulin), prescriber order dated January 3, 2025. -Novolog 100 units/ml; sliding scale: -If blood sugar greater than 240, give 20 units -If blood sugar is greater than 300, give 25 units -If blood sugar is greater than 360, give 30 units -If blood sugar is greater than 400, give 35 units -give 10 units with bedtime snack -gabapentin 100 mg; take one capsule by mouth twice daily (nerve pain); prescriber order dated February 5, 2025. -gabapentin 300 mg; take one capsule by mouth every night at bedtime (nerve pain); prescriber order dated February 5, 2025. -hydroxyzine 25 mg; take one tablet by mouth daily (anxiety); prescriber order dated February 3, 2025. -levothyroxine 88 micrograms (mcg); take one tablet by mouth daily (thyroid); prescriber order dated July 1, 2024. -lithium 450 mg; take one tablet by mouth daily at noon (mood stabilizer); prescriber order dated	01730		

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01730	Continued From page 63 February 4, 2025. -lurasidone 120 mg; take one tablet by mouth every night at bedtime (antipsychotic); prescriber order dated November 15, 2024. -melatonin 5 mg; take two tablets by mouth at bedtime (sleep); prescriber order dated December 14, 2024. -metformin 500 mg; take two tablets by mouth every evening (diabetes); prescriber order dated January 23, 2025. -risperdal 50 mg injection; inject 50 mg intramuscularly every two weeks; prescriber order dated July 16, 2024. -sertraline 100 mg; take one tablet by mouth daily (depression); prescriber order dated February 4, 2025. -Vitamin B12 1,000 mcg; take one tablet by mouth daily (supplement); prescriber order dated February 5, 2025. -acetaminophen 325 mg; take one to two tablets by mouth every four hours as needed (pain); prescriber order dated February 21, 2024. -albuterol HFA inhaler; inhale one to two puffs four times daily as needed for cough or wheezing; prescriber order dated December 4, 2023. -banophen 25 mg; take one capsule by mouth every four hours as needed (itching); prescriber order dated December 2, 2024. -benzonatate 100 mg; take one capsule by mouth three times daily as needed (cough); prescriber order dated September 12, 2024. -diclofenac gel 1%; apply as directed to lower back, shoulders, neck, and left hip three times daily as needed (pain); prescriber order dated April 17, 2024. -hydroxyzine 50 mg; take one half tablet by mouth twice daily as needed (anxiety) -Imodium 2 mg; take two tablets by mouth after first loose stool, then one tablet after each loose stool	01730		

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01730	Continued From page 64 -Maalox, Mylanta or generic equivalent (liquid antacid); take 5-10 ml by mouth one time daily between meal and bedtime as needed (heartburn or upset stomach) -meclizine 25 mg; take one tablet by mouth as needed (dizziness) -sumatriptan 50 mg; take one tablet by mouth every two hours as needed for headache; prescriber order dated December 27, 2024. -TUMS; take 2-4 tablets by mouth as needed between meals and at bedtime for heartburn or upset stomach -valacyclovir 1 gram (gm); take one tablet by mouth twice daily as needed for herpes outbreak); prescriber order dated July 15, 2024. R1's record lacked prescriber orders for the following medications; -hydroxyzine 50 mg; take one half tablet by mouth twice daily as needed (anxiety) -Immodium 2 mg; take two tablets by mouth after first loose stool, then one tablet after each loose stool -Maalox, Mylanta or generic equivalent (liquid antacid); take 5-10 ml by mouth one time daily between meal and bedtime as needed (heartburn or upset stomach) -meclizine 25 mg; take one tablet by mouth as needed (dizziness) -TUMS; take 2-4 tablets by mouth as needed between meals and at bedtime for heartburn or upset stomach R1's record lacked evidence of a medication management plan to include: - statement describing the medication management services that will be provided; - description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's	01730		

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01730	Continued From page 65 directions; - documentation of specific resident instructions relating to the administration of medications; - identification of persons responsible for monitoring medication supplies and ensuring medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; - procedures for staff notifying a registered nurse (RN) when a problem arose with medication management services and; - any resident-specific requirements relating to documenting mediation administration, verifications that all medications are administered as prescribed, and monitoring of medication to use to prevent possible complications or adverse reactions. R2 R2 was admitted on March 13, 2023, with diagnoses that included diabetes and schizoaffective disorder (mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania and a milder form of mania called hypomania). On February 19, 2025, at 7:35 a.m., the surveyor observed ULP-D administer medications to R2. R2's care plan (used as the service plan) dated December 17, 2024, indicated R2 received assistance with medication administration. R2's MAR dated February 2025, included the following medications: -amlodipine 10 mg; take one tablet by mouth daily *hold for SBP less than 120* (blood pressure); prescriber order dated October 21, 2024.	01730		

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01730	Continued From page 66 -chlorhexidine gluconate 0.12 %; rinse with 15 ml for thirty seconds once daily then spit, nothing by mouth for thirty minutes after use) (medicated mouthwash); prescriber order dated October 23, 2024. -cyclobenzaprine 10 mg; take one tablet by mouth three times daily (muscle spasms); prescriber order dated October 21, 2024. -docusate/senna 50-8.6 mg; take two tablets by mouth twice daily (constipation); prescriber order dated October 21, 2024. -erythromycin ointment 5 mg/gram; apply 0.25 inch to right eye every evening; prescriber order dated February 4, 2025. -escitalopram 20 mg; take one tablet by mouth daily (depression); prescriber order dated September 17, 2024. -Humalog 100 units/ml; inject 10 units subcutaneously three times daily with meals (insulin); prescriber order dated April 8, 2024. -Invega 156 mg/ml; inject 156 mg intramuscularly every four weeks (schizophrenia); prescriber order dated September 17, 2024. -Lantus 100 units/ml; inject 25 units subcutaneously twice daily (insulin); prescriber order dated January 2, 2025. -loratadine 10 mg; take one tablet by mouth daily (allergies); prescriber order dated April 6, 2024. -MAPAP Arthritis 650 mg; take two tablets by mouth every eight hours (pain); prescriber order dated January 2, 2025. -metformin 500 mg; take one tablet by mouth twice daily with meals (diabetes) -natural fiber powder 283%; mix one teaspoon in liquid and drink by mouth daily (constipation); prescriber order dated September 25, 2024. -polyethylene glycol; mix 17 grams into liquid then take by mouth daily (constipation); prescriber order dated January 13, 2025. -polyvinyl Al solution 1.4%; instill one drop in both	01730		

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01730	Continued From page 67 eyes twice daily; prescriber order dated January 30, 2025. -prazosin 1 mg; take one capsule by mouth every night at bedtime (blood pressure); prescriber order dated September 17, 2024. -prednisolone ophthalmic solution; instill one drop in right eye four times daily -rosuvastatin 10 mg; take one tablet by mouth every night at bedtime (cholesterol); prescriber order dated May 1, 2024. -Trazodone 50 mg; take one tablet by mouth every night at bedtime (sleep); prescriber order dated September 17, 2024. -docusate sodium 100 mg; take one capsule by mouth twice daily as needed (constipation); prescriber order dated March 26, 2024. -hydroxyzine pamoate 25 mg; take one capsule by mouth every six hours as needed (anxiety) -milk of magnesia; 15 ml by mouth once daily as needed (constipation) -milk of magnesia; 15-30 ml by mouth every day as needed (constipation) -nicotine gum 2 mg; take one piece by mouth every hour as needed (smoking) -ondansetron 4 mg; take one tablet by mouth every six hours as needed (nausea/vomiting) -onelax suppository 10 mg; insert one suppository rectally daily as needed (constipation) -Trazodone 100 mg; take one half tablet by mouth at bedtime as needed (sleep) R2's record lacked prescriber orders for the following medications: -Metformin 500 mg; take one tablet by mouth twice daily with meals (diabetes) -prednisolone ophthalmic solution; instill one drop in right eye four times daily -hydroxyzine pamoate 25 mg; take one capsule by mouth every six hours as needed (anxiety) -milk of magnesia; 15 ml by mouth once daily as	01730		

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01730	Continued From page 68 needed (constipation) -milk of magnesia; 15-30 ml by mouth every day as needed (constipation) -nicotine gum 2 mg; take one piece by mouth every hour as needed (smoking) -ondansetron 4 mg; take one tablet by mouth every six hours as needed (nausea/vomiting) -onelax suppository 10 mg; insert one suppository rectally daily as needed (constipation) -Trazodone 100 mg; take one half tablet by mouth at bedtime as needed (sleep) R2's record lacked evidence of a medication management plan to include: - statement describing the medication management services that will be provided; - description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - documentation of specific resident instructions relating to the administration of medications; - identification of persons responsible for monitoring medication supplies and ensuring medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; - procedures for staff notifying a registered nurse (RN) when a problem arose with medication management services and; - any resident-specific requirements relating to documenting mediation administration, verifications that all medications are administered as prescribed, and monitoring of medication to use to prevent possible complications or adverse reactions. R3 R3 was admitted on January 25, 2023, with diagnosis that included diabetes.	01730		

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01730	Continued From page 69 On February 18, 2025, at 12:11 p.m., the surveyor observed ULP-D administer medications to R3. R3's care plan (used as the service plan) dated February 19, 2025, indicated R3 received assistance with medication administration. R3's MAR dated February 2025, included the following medications: -aspirin 81 mg; take one tablet by mouth daily (blood thinner); prescriber order dated February 11, 2025. -duloxetine 60 mg; take one capsule by mouth daily (depression); prescriber order dated February 11, 2025. -fluticasone furoate 200 mcg; inhale one puff by mouth once daily (asthma); prescriber order dated February 27, 2024. -furosemide 20 mg; take one tablet by mouth every morning (diuretic); prescriber order dated February 11, 2025. -gabapentin 300 mg; take one capsule by mouth every night at bedtime (nerve pain); prescriber order dated February 11, 2025. -hydrocodone/acetaminophen 7.5/325 mg; take one tablet by mouth every six hours as needed (pain); prescriber order dated February 3, 2025. -ipratropium/albuterol; inhale one ampule via nebulizer four times a day (shortness of breath); prescriber order dated December 19, 2024. -Januvia 100 mg; take one tablet by mouth daily (diabetes); prescriber order dated January 13, 2025. -Lantus 100 units/ml; Inject 20 units subcutaneously at bedtime (insulin); prescriber order dated August 9, 2024. -levothyroxine 150 micrograms (mcg); take one tablet by mouth daily (thyroid); prescriber order	01730		

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01730	Continued From page 70 dated February 11, 2025. -metformin 1,000 mg; take one tablet by mouth twice daily with meals (diabetes); prescriber order dated February 11, 2025. -montelukast 10 mg; take one tablet by mouth at bedtime (asthma); prescriber order dated February 11, 2025. -omeprazole 20 mg; take one capsule twice daily (heartburn); prescriber order dated January 13, 2025. -potassium chloride 10 meq; take one tablet by mouth twice daily (supplement); prescriber order dated February 11, 2025. -quetiapine 25 mg; take one tablet by mouth every morning along with 50 mg tablet (to equal 75 mg) (anxiety); prescriber order dated February 11, 2025. -quetiapine 50 mg; take one tablet by mouth every morning and afternoon (anxiety); prescriber order dated February 11, 2025. -quetiapine 400 mg; take one tablet by mouth every night at bedtime (anxiety); prescriber order dated February 11, 2025. -rosuvastatin 20 mg; take one tablet by mouth every night at bedtime (cholesterol); prescriber order dated January 13, 2025. -tolterodine 2 mg; take one capsule by mouth daily (urinary incontinence); prescriber order dated February 11, 2025. -Vitamin B12 1,000 mcg; take one tablet by mouth daily (supplement); prescriber order dated November 20, 2024. -Vitamin D3 50 mcg; take one tablet by mouth daily (supplement); prescriber order dated February 11, 2025. -zolpidem tartrate 10 mg; take one tablet my mouth daily (sleep); prescriber order dated November 15, 2024. -albuterol Nebulizer 0.083%; inhale one ampule via nebulizer every four hours as needed	01730		

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01730	Continued From page 71 (wheezing/cough/shortness of breath) -hydroxyzine 25 mg; take one tablet by mouth three times daily as needed (anxiety); prescriber order dated November 13, 2023. -milk of magnesia; take 15-30 ml by mouth every day as needed (constipation) R3's record lacked prescriber orders for the following medications: -albuterol Nebulizer 0.083%; inhale one ampule via nebulizer every four hours as needed (wheezing/cough/shortness of breath) -milk of magnesia; take 15-30 ml by mouth every day as needed (constipation) R3's record lacked evidence of a medication management plan to include: - statement describing the medication management services that will be provided; - description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - documentation of specific resident instructions relating to the administration of medications; - identification of persons responsible for monitoring medication supplies and ensuring medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; - procedures for staff notifying a registered nurse (RN) when a problem arose with medication management services and; - any resident-specific requirements relating to documenting mediation administration, verifications that all medications are administered as prescribed, and monitoring of medication to use to prevent possible complications or adverse reactions.	01730		

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01730	Continued From page 72 On February 20, 2025, at 10:44 a.m., clinical nurse supervisor (CNS)-B stated R1, R2, and R3's record lacked an individualized medication management plan. CNS-B stated she was not aware of the required content of the individualized medication management plan and the electronic health record (EHR) system used did not have an option to create a medication plan for any of the residents. Licensed assisted living director (LALD)-A stated she would work with the software company to ensure they have access to all templates as they are Assisted Living driven and should have all the required assessments available to them. The licensee's Medication Management Individualized Plan policy dated August 1, 2023, indicated the [Licensee] would develop and maintain a current individualized mediation management record for each resident based on the resident's assessment that must contain the following: -a statement describing the medication management services that will be provided -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions -documentation of specific resident instructions relating to the administration of medications -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on timely basis -identification of medication management tasks that may be delegated to unlicensed personnel -procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services, and -any resident-specific requirements relating to	01730		

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01730	Continued From page 73 documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01750 SS=F	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). The licensee failed to ensure insulin via prefilled insulin pen was administered according to manufacturer instructions by two of two ULP (ULP-C and ULP-D).	01750		

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01750	Continued From page 74 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: RESIDENT SPECIFIC INSTRUCTIONS: R1 R1 was admitted on January 24, 2019, with diagnoses that included diabetes. On February 18, 2025, at 10:58 a.m., the surveyor observed ULP-C administer medications to R1. R1's care plan (used as the service plan) dated November 12, 2024, indicated R1 received assistance with medication administration. R1's Medication Administration Record (MAR) dated February 2025, included the following medications: -acetaminophen 325 milligrams (mg); take one to two tablets by mouth every four hours as needed (pain); prescriber order dated February 21, 2024. -albuterol HFA inhaler; inhale one to two puffs four times daily as needed for cough or wheezing; prescriber order dated December 4, 2023. -TUMS; take 2-4 tablets by mouth as needed between meals and at bedtime for heartburn or upset stomach	01750		

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01750	Continued From page 75 R1's record lacked prescriber orders for TUMs. The licensee failed to have resident-specific instructions regarding when to give one or two tablets of acetaminophen, when to give one or two puffs of the albuterol inhaler and when to give two or up to four tablets of TUMs. R2 R2 was admitted on March 13, 2023, with diagnoses that included diabetes and schizoaffective disorder (mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania and a milder form of mania called hypomania). On February 19, 2025, at 7:35 a.m., the surveyor observed ULP-D administer medications to R2. R2's care plan (used as the service plan) dated December 17, 2024, indicated R2 received assistance with medication administration. R2's MAR dated February 2025, included the following medication: -milk of magnesia; 15-30 milliliter (ml) by mouth every day as needed (constipation) The licensee failed to have resident-specific instructions regarding when to give 15 or 30 ml of milk of magnesia. R3 R3 was admitted on January 25, 2023, with diagnosis that included diabetes. On February 18, 2025, at 12:11 p.m., the surveyor observed ULP-D administer medications	01750		

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01750	Continued From page 76 to R3. R3's care plan (used as the service plan) dated February 19, 2025, indicated R3 received assistance with medication administration. R3's MAR dated February 2025, included the following medication: -milk of magnesia; take 15-30 ml by mouth every day as needed (constipation) R3's record lacked prescriber orders for milk of magnesia. The licensee failed to have resident-specific instructions regarding when to give 15 or 30 ml of milk of magnesia. On February 19, 2025, at 1:08 p.m., clinical nurse supervisor (CNS)-B stated there were no specific instructions regarding when to administer specific doses for R1, R2, and R3's medications listed above. CNS-B stated she was unaware that prescriber orders could not contain ranges without resident-specific instructions. The licensee's Medication and Treatment Orders policy dated August 1, 2024, indicated an order for medication or treatment must contain the name of the resident, a description of the medication, treatment, or therapy to be provided and the frequency, duration, and other information needed to carry out the order. INSULIN ADMINISTRATION: R1 R1's signed prescriber orders dated January 3, 2025, included the following medication order: -Novolog 100 units/ml); inject 12 units	01750		

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01750	Continued From page 77 subcutaneously three times daily before meals On February 19, 2025, at 7:14 a.m., ULP-C handed R1 her Novolog insulin pen and told R1 to dial 12 units of insulin. R1 removed the cap from the pen and attached a new needle to the port. R1 did not cleanse the end of the port with an alcohol swab prior to attaching the needle. R1 dialed the insulin pen to 12 units, gave the insulin pen to ULP-C to verify it was the correct dose. ULP-C verified the insulin pen was dialed to the prescribed 12 units. R1 then self-injected the insulin. R1 did not prime the insulin pen prior to dialing the prescribed dose. ULP-C did not instruct R1 to prime the insulin pen prior to dialing the prescribed dose. R2 R2's prescriber orders included the following medication orders: -Humalog 100 units/ml; inject 10 units subcutaneously three times daily with meals (insulin); prescriber order dated April 8, 2024. -Lantus 100 units/ml; inject 25 units subcutaneously twice daily; prescriber order dated January 2, 2025. On February 19, 2025, at 7:25 a.m., ULP-D handed R2 his two insulin pens (Humalog and Lantus) and told R2 to dial the Humalog insulin pen to 10 units and dial the Lantus insulin pen to 25 units. R2 removed the cap from the Humalog pen and attached a new needle to the port. R2 did not cleanse the end of the port with an alcohol swab prior to attaching the needle. R2 dialed the Humalog insulin pen to 10 units. R2 then removed the cap from the Lantus insulin pen and attached a new needle to the port. R2 did not cleanse the end of the port with an alcohol swab prior to attaching the needle. R2 dialed the Lantus	01750		

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01750	Continued From page 78 insulin pen to 25 units. R2 gave ULP-D both insulin pens to ULP-D to verify it was the correct dose. ULP-D verified both insulin pens were dialed to the prescribed dose. R2 then self-injected the Humalog insulin and then the Lantus insulin. R2 did not prime either insulin pens prior to dialing the prescribed dose. ULP-D did not instruct R2 to prime either insulin pens prior to dialing the prescribed dose. On February 19, 2025, at 7:30 a.m., ULP-C and ULP-D stated residents were required to dial their own insulin pens; however, the ULP were to supervise, provide direction as needed and verify the correct dose was dialed prior to the resident self-injecting the insulin. ULP-C and ULP-D stated they were unaware that the port of the insulin pen should be cleansed with an alcohol swab prior to attaching the needle. ULP-C and ULP-D further stated they were not taught to prime the insulin pen prior to dialing the prescribed dose. R3 R3's signed prescriber order dated August 9, 2024, included the following medication order: -Lantus 100 units/ml; Inject 20 units subcutaneously at bedtime On February 19, 2025, at 8:24 a.m., the surveyor observed ULP-D administer medications to R3. At this time the surveyor inquired if R3 cleansed the port of the insulin pen prior to attaching the needle to the port and if she primed the insulin pen prior to dialing the prescribed dose. R3 stated she did not cleanse the port with an alcohol swab prior to attaching the needle and did not know that the insulin pen should be primed prior to dialing the prescribed dose.	01750		

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01750	Continued From page 79 On February 20, 2025, at 10:24 a.m., CNS-B stated the licensee had not taught the ULP or residents to cleanse the port of the insulin pen with an alcohol swab prior to attaching the new needle. CNS-B further stated the licensee had not taught the ULP or the residents to prime the insulin pens prior to dialing the prescribed dose. The manufacturer instructions for use for the insulin Novolog dated February 2023, indicated the following: A. Pull off the pen cap. Wipe the rubber stopper with an alcohol swab. B. remove the protective tab from a disposable needle. Screw the needle tightly onto your FlexPen. C. pull off the big outer needle cap D. Pull off the inner needle cap and throw it away E. Turn the dose selector to select 2 units F. Hold your Novolog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. G. Keep the needle pointing upwards, press the push-button all the way in. The dose selector returns to 0. A drop of insulin should appear at the needle tip. H. Turn the dose selector to the umber of units you need to inject. The pointer should line up with your dose. The manufacturer instructions for use for the Humalog Kwikpen dated 2023, indicated the following: -Step 1: Pull the pen cap straight off. Wipe the rubber seal with an alcohol swab. -Step 2: Check the liquid in the pen. It should look clear and colorless. Do not use if it is cloudy, colored, or has particles or clumps in it. -Step 3: pull off the paper tab from the outer	01750		

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01750	Continued From page 80 needle shield -Step 4: push the capped needle straight onto the pen and twist the needle on until it is tight -Step 5: pull off the outer needle shield. Do not throw it away. -Step 6: prime your pen, turn the dose knob to select 2 units -Step 7: Hold you pen with the needle pointing up. Tap the cartridge holder gently to collect air bubble at top. -Step 8: continue holding your pen with needle pointing up. Push the dose knob in until it stops, and "0" is seen in the dose window. Hold the dose knob in and count to 5 slowly. You should see insulin at the tip of the needle. The manufacturer instructions for use for the Lantus SoloStar pen dated August 2022, indicated the following: -Step 1: Remove the pen cap with clean hands. Check the reservoir to make sure the insulin is clear and colorless and has no particles- if not, use another pen. -Step 2: wipe the pen tip (rubber seal) with an alcohol swab. Remove the protective seal from the new needle, line the needle up straight with the pen, and screw the needle on. Do not make the needle too tight. If you have a push-on needle, keep it straight as you push it on. After you have attached the needle. Take off outer needle cap and save it (you will need it to remove the needle after your injection). Remove the inner needle cap and throw it away. -Step 3: Dial a test dose of two units. Hold pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. This will help you get the most accurate dose. Press the injection button all the way in and check to see that insulin comes out of the needle. The dial will automatically go back to	01750		

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01750	Continued From page 81 zero after you perform the test. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as ordered for two of three residents (R2 and R3) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01760		

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01760	Continued From page 82 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: R2 R2 was admitted on March 13, 2023, with diagnoses that included diabetes and schizoaffective disorder (mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania and a milder form of mania called hypomania). On February 19, 2025, at 7:35 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R2. R2's care plan (used as the service plan) dated December 17, 2024, indicated R2 received assistance with medication administration. R2's signed prescriber orders dated January 2, 2025, included: -nicotine 21 milligrams (mg)/24 hour daily transdermal patch; apply 1 patch on dry, clean, hairless skin once daily R2's MAR dated February 2025, did not include the nicotine patch. R3 R3 was admitted on January 25, 2023, with diagnosis that included diabetes. On February 18, 2025, at 12:11 p.m., the surveyor observed ULP-D administer medications to R3.	01760		

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01760	Continued From page 83 R3's care plan (used as the service plan) dated February 19, 2025, indicated R3 received assistance with medication administration. R3's signed prescriber orders dated February 18, 2025, included: -ferrous sulfate 325 mg; take one tablet by mouth once daily with a meal R3's MAR dated February 2025, did not include an order for ferrous sulfate. On February 19, 2025, at 1:11 p.m., clinical nurse supervisor (CNS)-B stated R2's nicotine order and R3's ferrous sulfate order had not been transcribed into their records. The licensee's Medication and Treatment Orders policy dated August 1, 2024, indicated the following: 1. The RN is responsible for assuring that: a. current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the residents' records b. communicated to the resident or responsible party c. educate resident or responsible party on all medication and treatment orders, and d. changes in orders are addressed in the resident's service plan and are communicated to the other staff. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01770	Continued From page 84	01770		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication set up included all the required content for licensee's two residents (R5 and R6) who received medication setup services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 February 18, 2025, at 9:21 a.m. during the entrance conference, clinical nurse supervisor (CNS)-B stated the licensee provided medication management services which also included medication set up for two residents. R5 R5 was admitted on April 14, 2015, with diagnoses that included hypertension (high blood pressure).	01770		

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01770	Continued From page 85 R5's care plan (also used as the service plan) dated December 10, 2024, indicated R5 received services to include medication administration. The care plan did not include medication setup services. R5's Medication Administration Record (MAR) dated February 2025, included the following medications: -allopurinol (gout) 100 milligram (mg); take one tablet by mouth daily -atorvastatin (cholesterol) 20 mg; take one-half tablet by mouth at bedtime -cyanocobalamin (supplement) 1,000 microgram (mcg); take one tablet by mouth every day -furosemide (diuretic) 20 mg; take one tablet by mouth daily -lisinopril (blood pressure) 40 mg; take one tablet by mouth daily -magnesium oxide (supplement) 420 mg; take one tablet by mouth every day R5's record lacked signed prescriber orders for R5's medications. R6 R6 was admitted on July 14, 2017, with diagnoses that included diabetes. R6's 90 Day Care Plan (also used as the service plan) dated January 16, 2023, indicated R6 received services to include medication administration. The care plan did not include medication setup services. R6's MAR dated February 2025, included the following medications: -anti-diarrhea 2 mg; take one tablet by mouth every night at bedtime	01770		

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01770	Continued From page 86 -banophen (allergies) 25 mg; take one capsule by mouth every night at bedtime -cetirizine (allergies) 10 mg; take one tablet by mouth daily -clonazepam (anxiety) 1 mg; take one twice daily -ezetimibe (cholesterol) 10 mg; take one tablet by mouth daily -fluconazole (fungal infection) 150 mg; take one tablet by mouth once weekly -glipizide (diabetes) 5 mg; take one tablet by mouth daily -lisinopril (blood pressure) 5 mg; take one tablet by mouth daily -metformin (diabetes) 1,000 mg; take one tablet by mouth twice daily -mucus relief 600 mg; take two tablets by mouth twice daily -Vitamin C (supplement) 500 mg; take one tablet by mouth daily -Vitamin D3 (supplement) 1,000 international unit (IU); take one tablet by mouth daily R6's MAR indicated "medications are set up weekly in a med-minder by nursing. Home Health Aides (HHA) will give resident medications at appropriate times that are scheduled. Nursing will fill med-minder weekly on Tuesdays." R6's record lacked signed prescriber orders for R6's medications. On February 19, 2025, at 1:55 p.m., CNS-B stated unlicensed personnel (ULP)-E set up R5 and R6's medications every week and did not document the medication setup. CNS-B stated she was unaware that ULP could not setup medications for later use, or the documentation requirements for medication setup. The licensee's Medication Management-Dosage	01770		

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01770	Continued From page 87 Box Setup policy dated August 1, 2024, indicated the following: 1. A licensed nurse will ensure the medication orders are transcribed onto the Medication Administration Record. This profile includes: a. Dates of medication set up b. Medication name c. Quantity of dose d. Times to be administered e. Route of administration f. Name of the person completing the medication setup g. Visual description of medication h. Drug classification and special precautions 2. The licensed nurse transcribes the medications order onto the MAR. For medications included in the dosage box, the day and time of administration will be noted of the MAR. 3. Medications that cannot be set up in the dosage box (topical or liquid) will be recorded on the MAR to include any special instructions and: a. medication name b. quantity of dose c. times to be administered d. route of administration e. visual description of medication f. drug classification and special precautions 4. the licensed nurse sets up medication weekly into the dosage boxes. 5. When the licensed nurse has completed setting up the medications into the dosage box, the set-up is documented on the MAR. 6. The licensed nurse will review the dosage boxes on weekly basis to assure that all the previous week's medications were administered, and documentation is then made on the MAR. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	01770		

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01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been	01790		

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01790	Continued From page 89 provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) developed training and competencies for two of two unlicensed personnel (ULP-C, ULP-D) providing medications to residents for unplanned time away from home when the licensed nurse was not available. In addition, the licensee failed to develop and implement a written procedure for unlicensed personnel providing medications for residents having unplanned times away from the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01790		

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01790	Continued From page 90 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: TRAINING AND COMPETENCY: ULP-C ULP-C was hired on February 24, 2024. ULP-C's employee record lacked documentation of training and competencies for providing medications for unplanned time away when the RN was not available. ULP-D ULP-D was hired on February 10, 2022. ULP-D's employee record lacked documentation of training and competencies for providing medications for unplanned time away when the RN was not available. WRITTEN PROCEDURE: On February 19, 2025, at 10:08 a.m., the surveyor observed ULP-C remove a prefilled medication box from the medication cart and give it to R7 to take with him on a leave of absence. The medication box was not labeled, and no documents were provided to R7 regarding the medications that were sent with him. After giving the medication box to R7, ULP-C logged into the electronic health record and marked R7 and "inactive". ULP-C stated R7 had told ULP-E that he was staying at a friend's house for a few days and ULP-E had set up R7's medications and left the medication box in the medication cart until R7	01790		

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01790	Continued From page 91 was ready to leave. The surveyor inquired how R7 knew what medications were included in the medication box, when to take the medications and what to do if he had any questions regarding the medications when he was on leave. ULP-C stated R7 "just knew" what to do with his medications. ULP-C stated if medications were given to a resident's family member, the ULP would verbally explain when to administer the medications. For unplanned time away the licensee had not developed written procedures for the ULP, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: -the type of container or containers to be used for the medications appropriate to the provider's medication system; -how the container or containers must be labeled; -written information about the medications to be provided; -how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number f medications that were provided to the resident, and other required information; -how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative -review by the registered nurse of the completion of this task to verify that this task completed accurately by the unlicensed personnel; and -how the unlicensed personnel must document in	01790		

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01790	Continued From page 92 the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. On February 19, 2025, at 1:05 p.m., clinical nurse supervisor (CNS)-B stated ULP-C and ULP-D were trained to provide medications to residents for unplanned time away, but their records lacked evidence of training and competencies. CNS-B further stated she was unaware of the content requirements for the planned and unplanned time away policy. The licensee's Medication Management- Planned and Unplanned Time Away policy dated August 1, 2024, indicated the following: For unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or properly trained and competency tested unlicensed personnel may give the resident or resident's representative medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven (7) calendar days with the following requirements: 1. The resident, or the resident's representative, must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances. 2. The medications must be placed in a medication container, or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. 3. The resident or resident's representative must be provided in writing the facility's contact information in case they have questions. 4. The process must be properly documented in the MAR and resident record including	01790		

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01790	Continued From page 93 documenting the date the medications were given to the resident or the resident's representative and who received the medications, the person who gave the medications to the resident, the number of medications that were given to the resident and other required information. For unplanned resident time away when a pharmacist or licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: 1. The registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents. 2. The registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: a. the type of container or containers to be used for the medications appropriate to the provider's medication system b. how the container or containers must be labeled c. the written information about the medications to be given to the resident or resident's representative d. how the unlicensed staff must document in the resident's record that medications have been given to the resident or the resident's representative, including documenting the date the medications were given to the resident or the resident's representative and who received the medications, the person who gave the medications to the resident, the number of medications that were given to the resident, and other required information e. how the registered nurse shall be notified	01790		

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01790	Continued From page 94 that medications have been given to the resident or resident's representative and whether the registered nurse needs to be contacted before the medications are given to the resident or the resident's representative f. a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel g. how the unlicensed staff must document in the resident's record any unused mediations that are returned to the provider, including the name of each medication and the doses of each returned medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for all medications the provider managed for five of five residents (R1, R2, R3, R5 and R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01820		

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01820	Continued From page 95 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: On February 18, 2025, at 11:24 a.m., the surveyor requested signed prescriber orders for R1, R2 and R3. On February 18, 2025, at 12:46 p.m., clinical nurse supervisor (CNS)-B stated she did not have signed prescriber orders for R1, R2, or R3 as the pharmacy entered all medication orders into the electronic health record. CNS-B stated she had the pharmacy fax copies of R1, R2, and R3's E-scripts; however, the pharmacy did not have E-Scripts for all medications administered to R1, R2, R3. CNS-B provided the surveyor the E-scripts that were faxed from the pharmacy. R1 R1 was admitted on January 24, 2019, with diagnoses that included diabetes. On February 18, 2025, at 10:58 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R1. R1's care plan (used as the service plan) dated November 12, 2024, indicated R1 received assistance with medication administration. R1's Medication Administration Record (MAR) dated February 2025, included the following medications:	01820		

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01820	Continued From page 96 -hydroxyzine 50 mg; take one half tablet by mouth twice daily as needed (anxiety) -Imodium 2 mg; take two tablets by mouth after first loose stool, then one tablet after each loose stool -Maalox, Mylanta or generic equivalent (liquid antacid); take 5-10 ml by mouth one time daily between meal and bedtime as needed (heartburn or upset stomach) -meclizine 25 mg; take one tablet by mouth as needed (dizziness) -TUMS; take 2-4 tablets by mouth as needed between meals and at bedtime for heartburn or upset stomach R1's record lacked signed prescriber orders for the medications listed above. R2 R2 was admitted on March 13, 2023, with diagnoses that included diabetes and schizoaffective disorder (mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania and a milder form of mania called hypomania). On February 19, 2025, at 7:35 a.m., the surveyor observed ULP-D administer medications to R2. R2's care plan (used as the service plan) dated December 17, 2024, indicated R2 received assistance with medication administration. R2's MAR dated February 2025, included the following medications: -metformin 500 mg; take one tablet by mouth twice daily with meals (diabetes) -prednisolone ophthalmic solution; instill one drop	01820		

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01820	Continued From page 97 in right eye four times daily -hydroxyzine pamoate 25 mg; take one capsule by mouth every six hours as needed (anxiety) -milk of magnesia; 15 ml by mouth once daily as needed (constipation) -milk of magnesia; 15-30 ml by mouth every day as needed (constipation) -nicotine gum 2 mg; take one piece by mouth every hour as needed (smoking) -ondansetron 4 mg; take one tablet by mouth every six hours as needed (nausea/vomiting) -onelax suppository 10 mg; insert one suppository rectally daily as needed (constipation) -trazodone 100 mg; take one half tablet by mouth at bedtime as needed (sleep) R2's record lacked signed prescriber orders for the medications listed above. R3 R3 was admitted on January 25, 2023, with diagnosis that included diabetes. On February 18, 2025, at 12:11 p.m., the surveyor observed ULP-D administer medications to R3. R3's care plan (used as the service plan) dated February 19, 2025, indicated R3 received assistance with medication administration. R3's MAR dated February 2025, included the following medications: -albuterol nebulizer 0.083%; inhale one ampule via nebulizer every four hours as needed (wheezing/cough/shortness of breath) -milk of magnesia; take 15-30 ml by mouth every day as needed (constipation) R3's record lacked signed prescriber orders for	01820		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01820	Continued From page 98 the medications listed above. R5 R5 was admitted on April 14, 2015, with diagnoses that included hypertension (high blood pressure). R5's care plan (used as the service plan) dated December 10, 2024, indicated R5 received services to include medication administration. R5's MAR dated February 2025, included the following medications: -allopurinol 100 mg; take one tablet by mouth daily (gout) -atorvastatin 20 mg; take one-half tablet by mouth at bedtime (cholesterol) -cyanocobalamin 1,000 mcg); take one tablet by mouth every day (supplement) -furosemide 20 mg; take one tablet by mouth daily (diuretic) -lisinopril 40 mg; take one tablet by mouth daily (blood pressure) -magnesium oxide 420 mg; take one tablet by mouth every day (supplement) R5's record lacked signed prescriber orders for R5's medications. R6 R6 was admitted on July 14, 2017, with diagnoses that included diabetes. R6's 90 Day Care Plan (used as the service plan) dated January 16, 2023, indicated R6 received services to include medication administration. R6's MAR dated February 2025, included the following medications:	01820		

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01820	Continued From page 99 -anti-diarrhea 2 mg; take one tablet by mouth every night at bedtime -banophen 25 mg; take one capsule by mouth every night at bedtime (allergies) -cetirizine 10 mg; take one tablet by mouth daily (allergies) -clonazepam 1 mg; take one twice daily (anxiety) -ezetimibe 10 mg; take one tablet by mouth daily (cholesterol) -fluconazole 150 mg; take one tablet by mouth once weekly (fugal infection) -glipizide 5 mg; take one tablet by mouth daily (diabetes) -lisinopril 5 mg; take one tablet by mouth daily (blood pressure) -metformin 1,000 mg; take one tablet by mouth twice daily (diabetes) -mucus relief 600 mg; take two tablets by mouth twice daily -Vitamin C 500 mg; take one tablet by mouth daily (supplement) -Vitamin D3 1,000 international unit (IU); take one tablet by mouth daily (supplement) R6's record lacked signed prescriber orders for R6's medications. On February 19, 2025, at 11:21 a.m., CNS-B stated R1, R2, R3, R5, and R6's records lacked signed prescriber orders as listed above. CNS-B stated she was unaware that she had to keep copies of all prescriber orders in the resident record and thought it was okay for the pharmacy to keep records of prescriber orders. The licensee's Medication and Treatment Orders policy dated August 1, 2024, indicated the registered nurse was responsible for assuring that current, authorized prescriber orders for medication or treatments administered by the	01820		

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01820	Continued From page 100 staff were kept on file in the residents' records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01830 SS=F	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to renew prescriptions at least every 12 months 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 January 24, 2019, with diagnoses that included diabetes. On February 18, 2025, at 10:58 a.m., the	01830		

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01830	Continued From page 101 surveyor observed unlicensed personnel (ULP)-C administer medications to R1. R1's care plan (used as the service plan) dated November 12, 2024, indicated R1 received assistance with medication administration. The following prescriber order lacked evidence of being renewed annually: -albuterol HFA inhaler; inhale one to two puffs four times daily as needed for cough or wheezing; prescriber order dated December 4, 2023. R3 R3 was admitted on January 25, 2023, with diagnosis that included diabetes. On February 18, 2025, at 12:11 p.m., the surveyor observed ULP-D administer medications to R3. R3's care plan (used as the service plan) dated February 19, 2025, indicated R3 received assistance with medication administration. The following prescriber order lacked evidence of being renewed annually: -hydroxyzine 25 milligrams (mg); take one tablet by mouth three times daily as needed (anxiety); prescriber order dated November 13, 2023. On February 19, 2025, at 11:21 a.m., clinical nurse supervisor (CNS)-B stated R1 and R3's prescriber orders listed above had not been renewed at least annually as required. CNS-B stated she was not aware that prescriber orders were required to be renewed annually and did not have a process for tracking this for any of the residents receiving medication management services.	01830		

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01830	Continued From page 102 The licensee's Medication and Treatment Orders-Renewal policy dated August 1, 2024, indicated medication and treatment orders must be renewed at least every 12 months or more frequently as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01910		

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01910	Continued From page 103 licensee failed to document in the resident's record the disposition of the medications as required for one of one discharged resident (R4). 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: R4 was admitted to the licensee on November 19, 2018, and discharged on February 6, 2025. R4's Medication Administration Record (MAR) dated February 2025, indicated R4 received medication administration to include the following medications: -abiraterone 500 milligram (mg); take one tablet by mouth daily with food (prostate cancer) -atorvastatin 20 mg; take one tablet by mouth daily (cholesterol) -banophen 50 mg; take one capsule by mouth three times daily (antihistamine) -ferrous sulfate 45 mg; take one tablet by mouth daily (vitamin supplement) -fish oil 1,000 mg; take one capsule by mouth daily (vitamin supplement) -hydrocortisone 10 mg; take two tablets by mouth every morning (inflammation) -hydrocortisone 10 mg; take one tablet by mouth daily in the late afternoon (inflammation) -propranolol 60 mg; take one capsule by mouth daily (blood pressure) -thiothixene 10 mg; take one capsule by mouth	01910		

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01910	Continued From page 104 every morning (antipsychotic) -thiothixene 5 mg; take one capsule by mouth every night at bedtime (antipsychotic) -vitamin B-12 100 microgram (mcg); take one tablet by mouth daily (vitamin supplement) -vitamin D3 50 mcg; take one tablet by mouth daily (vitamin supplement) -vitamin E 400 units; take one capsule by mouth daily (vitamin supplement) R4's progress notes dated February 5, 2025, indicated "Resident moved this morning to a group home in [city of group home]. He was picked up by the facility, meds and belongings were sent with". R4's record lacked a medication disposition record at the time of discharge to include the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. On February 18, 2025, at 2:19 p.m., clinical nurse supervisor (CNS)-B stated she was unaware of the required content for documenting disposition of medications. CNS-B stated when a resident discharged, she would document in a progress note to whom she sent the resident's medications with, however, the progress notes did not include the required content as listed above. The licensee's Medication Disposal policy dated August 1, 2024, indicated upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, date of disposition, ad names of staff and other individuals involved in	01910		

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01910	Continued From page 105 the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
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	01940		

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01940	Continued From page 106 changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for three of three residents (R1, R2, 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 January 24, 2019, with diagnoses that included diabetes and hypertension (high blood pressure). R1's care plan (used as the service plan) dated November 12, 2024, indicated R1 received assistance with daily blood pressure checks and blood glucose checks three times a day. On February 18, 2025, at 10:58 a.m., the surveyor observed unlicensed personnel (ULP)-C supervise R1 check her blood sugar. R1's Medication Administration Record (MAR) dated February 2025, indicated R1's blood sugar was checked three times a day and R1's blood pressure was checked once a day.	01940		

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01940	Continued From page 107 R1's record lacked prescriber orders for the following treatments: -blood sugar checks three times a day -daily blood pressure check R1's record lacked evidence of an Individualized Treatment or Therapy 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 or appropriate licensed health professional when a problem arises 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. R2 R2 was admitted on March 13, 2023, with diagnoses that included diabetes, hypertension (high blood pressure) and schizoaffective disorder (mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania and a milder form of mania called hypomania). R2's care plan (used as the service plan) dated December 17, 2024, indicated R2 received services to include blood sugar monitoring. The	01940		

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01940	Continued From page 108 care plan did not include daily blood pressure checks. On February 19, 2025, at 7:25 a.m., the surveyor observed ULP-D supervise R2 check his blood sugar. R2's MAR dated February 2025, indicated R2's blood sugar was checked four times a day. R2's record lacked documentation of blood pressure checks. R2's prescriber orders included the following: -Accu-Check; test four times a day, prescriber order dated April 8, 2024. -amlodipine 10 milligrams (mg); take one tablet by mouth daily, check blood pressure, *hold for SBP less than 120*, prescriber order dated October 21, 2024. R2's record lacked evidence of an Individualized Treatment or Therapy 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 or appropriate licensed health professional when a problem arises 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.	01940		

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01940	Continued From page 109 R3 R3 was admitted on January 25, 2023, with diagnosis that included diabetes. R3's care plan (used as the service plan) dated February 19, 2025, indicated R3 received services to include documentation of blood glucose checks. R3's MAR dated February 2025, indicated R3's blood sugar was checked twice a day. R3's record lacked prescriber orders for blood sugar checks. R3's record lacked evidence of an Individualized Treatment or Therapy 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 or appropriate licensed health professional when a problem arises 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 February 18, 2025, at 2:11 p.m., clinical nurse supervisor (CNS)-B stated R1, R2, and R3's record lacked and individualized treatment	01940		

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01940	Continued From page 110 management plan to include the required content as listed above. CNS-B further stated the electronic health record used for all assessments did not have an option for a treatment plan so none of the residents at the licensee with treatments had a treatment plan. The licensee's Treatment and Therapy Management Plan policy dated August 1, 2024, indicated the following: 1. [Licensee] will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: a. A statement of the type of services that will be provided b. Documentation of specific resident instructions relating to the treatments or therapy administration c. Identification of treatment or therapy tasks that will be delegated to unlicensed personnel d. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services e. Any resident-specific requirements relating to documentation of treatment and therapy received f. Verification that all treatment and therapy was administered as prescribed g. Monitoring of treatment or therapy to prevent possible complications or adverse reactions 2. The treatment or therapy management record must be current and updated when there are any changes No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

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01960	Continued From page 111	01960		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure treatment or therapies were administered as prescribed, or to document the reason they were not provided, for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted on March 13, 2023, with diagnoses that included diabetes, hypertension (high blood pressure) and schizoaffective disorder (mental health condition that is marked	01960		

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01960	Continued From page 112 by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania and a milder form of mania called hypomania). R2's care plan (used as the service plan) dated December 17, 2024, indicated R2 received services to include housekeeping, laundry, bathing assist, cues/reminders to complete activities of daily living, grooming, blood sugar monitoring and medication administration. The service plan did not include daily blood pressure checks. R2's prescriber orders dated October 21, 2024, included: -amlodipine 10 milligrams (mg); take one tablet by mouth daily, check blood pressure, *hold for SBP less than 120* R2's MAR dated February 2025, indicated R2's blood sugar was checked four times a day. R2's record lacked documentation of blood pressure checks. On February 19, 2025, at 1:12 p.m., clinical nurse supervisor (CNS)-B stated R2's blood pressure was not checked daily. CNS-B reviewed the prescriber order for daily blood pressure checks and stated it was missed and never transcribed into R2's record. The licensee's Medication and Treatment Orders policy dated August 1, 2024, indicated the following: 1. The registered nurse is responsible for assuring that: a. A current authorized prescriber orders for medications or treatments administered by the staff are kept on file in the residents' records	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30330	A. BUILDING: _____ B. WING _____	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEYVIEW OF NORTHFIELD	812 LINDEN STREET N NORTHFIELD, MN 55057

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01960	Continued From page 113 b. Communicated to the resident or responsible party c. Educate resident or responsible part on all medication and treatment orders, and d. Changes in orders are addressed in the resident's service plan and are communicated to other staff. 7. the license nurse will also monitor and evaluate medication and treatment/therapy orders and services for effectiveness on a regular basis 8. a resident's MAR and treatment administration record will be audited regularly by licensed nurse or designee for documentation compliance No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for two of three residents (R1 and R3) receiving treatments.	01970		

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01970	Continued From page 114 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: R1 R1 was admitted on January 24, 2019, with diagnoses that included diabetes and hypertension (high blood pressure). R1's care plan (used as the service plan) dated November 12, 2024, indicated R1 received assistance with housekeeping, laundry, meals, daily blood pressure checks, blood glucose checks three times a day and medication administration. On February 18, 2025, at 10:58 a.m., the surveyor observed unlicensed personnel (ULP)-C supervise R1 check her blood sugar. R1's Medication Administration Record (MAR) dated February 2025, indicated R1's blood sugar was checked three times a day and R1's blood pressure was checked once a day. R1's record lacked prescriber orders for the following treatments: -blood sugar checks three times a day -daily blood pressure check R3 R3 was admitted on January 25, 2023, with	01970		

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	30330	A. BUILDING: _____ B. WING _____	02/20/2025

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VALLEYVIEW OF NORTHFIELD	812 LINDEN STREET N NORTHFIELD, MN 55057

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01970	Continued From page 115 diagnosis that included diabetes. R3's care plan (used as the service plan) dated February 19, 2025, indicated R3 received services to include housekeeping, laundry, bathing setup, documentation of blood glucose checks, and medication administration. R3's MAR dated February 2025, indicated R3's blood sugar was checked twice a day. R3's record lacked prescriber orders for blood sugar checks. On February 18, 2025, at 2:11 p.m., clinical nurse supervisor (CNS)-B stated R1 and R3's record lacked prescriber orders for the treatments listed above. The licensee's Medication and Treatment Orders policy dated August 1, 2024, indicated the registered nurse was responsible for assuring that a current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the residents' records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02310 SS=I	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.	02310		

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VALLEYVIEW OF NORTHFIELD	812 LINDEN STREET N NORTHFIELD, MN 55057

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02310	Continued From page 116 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 two of two residents (R1 and R3) with bed rails. This resulted in an immediate correction order issued on February 19, 2025. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted on January 24, 2019, with diagnoses that included diabetes. R1's care plan dated November 12, 2024, indicated R1 received assistance with housekeeping, laundry, meals, daily blood pressure checks, blood glucose checks three times a day and medication administration. On February 19, 2025, at 8:00 a.m., the surveyor observed R1's bed to have an upside down "U" shaped consumer bed rail attached on the left side of the bed. However, the legs of the bed rail were not touching the ground and the bar leaned into the bed towards the mattress. R1 stated the bed rail was installed by the facility maintenance	02310		

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VALLEYVIEW OF NORTHFIELD	812 LINDEN STREET N NORTHFIELD, MN 55057

(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
02310	Continued From page 117 worker about a year ago. R1 stated she used the bed rail to assist with getting in and out of bed and repositioning. R1's record lacked evidence of the following: - bed rail assessment - documentation of a risk versus benefits discussion - manufacturer instructions for the bed rail - evidence the bed rail was installed, used, and maintained per manufacturer's guidelines - evidence of checking the Consumer Product Safety Commission (CPSC) for recalls On February 19, 2025, at 9:22 a.m., clinical nurse supervisor (CNS)-B reviewed R1's record and provided a side rail assessment dated September 20, 2022; however, the assessment indicated R1 did not utilize side rails. CNS-B stated R1's record lacked the required documentation for bed rail use as listed above. CNS-B further stated she was not aware of the requirements to obtain manufacturer instructions for consumer bed rails, document that the bed rail was installed, used, and maintained per manufacturer's guidelines and check the CPSC for recalls. - At 9:26 a.m., the surveyor and CNS-B observed R1's bed rail and CNS-B stated the bed rail legs were not touching the floor as they should, and it appeared that the bed rail leaned in towards the mattress. R3 R3 was admitted on January 25, 2023, with diagnosis that included diabetes. On February 18, 2025, at 12:50 p.m., the surveyor observed R3's room to have a hospital bed with bilateral upper side rails. R3 stated she used the side rails to aid in getting in and out of	02310		

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02310	Continued From page 118 bed and turning on her side while laying down. R3's side rail assessment dated February 13, 2023, indicated R3 utilized a hospital bed with bilateral siderails to aid in transfers to and from bed, and turning and repositioning in bed. It also indicated R3 had been educated on the risks and benefits of using side rails. The assessment lacked documentation of the measurements of the side rails zones one through four. On February 19, 2025, at 9:19 a.m., CNS-B stated R3's side rail assessment did not include zone measurements for R3's side rails. CNS-B further stated she thought hospital bed came with standard side rails and did not require zone measurements. The licensee's Side Rails policy dated August 1, 2024, indicated the following: 1. When side rails are in use, an RN must conduct an assessment to identify the intended purpose of the side rail and the risks regarding the use of the side rail. If the side rail is acting as a restraint, appropriate action should be taken. 2. Staff will determine if the side rail is safe. "Safe" shall be defined as meeting all the requirements listed below: a. The side rail is used consistent with manufacturer's directions. Be aware of side rails that slide between the mattress and box spring designed for toddler use. b. The side rails are installed securely and maintained in good operating condition. Be aware of "wobbly" side rails. c. The side rail design is consistent with the FDA's 2006 recommended dimensional measurements to reduce entrapment. This means side rail zones 1,2, and 3 must not exceed 4.75".	02310		

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02310	Continued From page 119 3. The resident and, when appropriate, the resident's representative, shall be informed of the risks and benefits regarding the use of side rails. Education provided will be documented in the resident record. 4. The licensee will inform local known hospice providers and known medical equipment suppliers that residents will only be permitted to use side rails that comply with the 2006 FDA dimensional guidance to reduce entrapments. Assessments and Education procedures must still be followed. 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, 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	02310		

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02310	Continued From page 120 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". No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE On February 19, 2025, the licensee implemented actions to mitigate the risk to R1 and R3. Scope and severity remain at I.	02310		
02320 SS=I	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan.	02320		

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02320	Continued From page 121 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 the licensee's two residents (R5 and R6) who received medication setup services. This resulted in an immediate correction order issued on February 19, 2025. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 18, 2025, at 9:21 a.m. during the entrance conference, clinical nurse supervisor (CNS)-B stated the licensee provided medication management services which also included medication set up for two residents. R5 R5 was admitted on April 14, 2015, with diagnoses that included hypertension (high blood pressure). R5's care plan (also used as the service plan) dated December 10, 2024, indicated R5 received services to include medication administration. The care plan did not include medication setup services.	02320		

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02320	Continued From page 122 R5's Medication Administration Record (MAR) dated February 2025, included the following medications: -allopurinol (gout) 100 milligram (mg); take one tablet by mouth daily -atorvastatin (cholesterol) 20 mg; take one-half tablet by mouth at bedtime -cyanocobalamin (supplement) 1,000 microgram (mcg); take one tablet by mouth every day -furosemide (diuretic) 20 mg; take one tablet by mouth daily -lisinopril (blood pressure) 40 mg; take one tablet by mouth daily -magnesium oxide (supplement) 420 mg; take one tablet by mouth every day R5's record lacked signed prescriber orders for R5's medications. R6 R6 was admitted on July 14, 2017, with diagnoses that included diabetes. R6's 90 Day Care Plan (also used as the service plan) dated January 16, 2023, indicated R6 received services to include medication administration. The care plan did not include medication setup services. R6's MAR dated February 2025, included the following medications: -anti-diarrhea 2 mg; take one tablet by mouth every night at bedtime -banophen (allergies) 25 mg; take one capsule by mouth every night at bedtime -cetirizine (allergies) 10 mg; take one tablet by mouth daily -clonazepam (anxiety) 1 mg; take one twice daily -ezetimibe (cholesterol) 10 mg; take one tablet by	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02320	Continued From page 123 mouth daily -fluconazole (fungal infection) 150 mg; take one tablet by mouth once weekly -glipizide (diabetes) 5 mg; take one tablet by mouth daily -lisinopril (blood pressure) 5 mg; take one tablet by mouth daily -metformin (diabetes) 1,000 mg; take one tablet by mouth twice daily -mucus relief 600 mg; take two tablets by mouth twice daily -Vitamin C (supplement) 500 mg; take one tablet by mouth daily -Vitamin D3 (supplement) 1,000 international unit (IU); take one tablet by mouth daily R6's MAR indicated "medications are set up weekly in a med-minder by nursing. Home Health Aides (HHA) will give resident medications at appropriate times that are scheduled. Nursing will fill med-minder weekly on Tuesdays." R6's record lacked signed prescriber orders for R6's medications. On February 19, 2025, at 1:55 p.m., the surveyor requested documentation for medication setup for R5 and R6. CNS-B stated unlicensed personnel (ULP)-E set up R5 and R6's medications every week and did not document the medication setup. CNS-B stated she was not aware that ULP could not setup medications for later use. The licensee did not ensure care and services were provided according to acceptable health care and nursing standards when setting up medications for later use was completed by a ULP instead of a licensed nurse, pharmacy, or authorized prescriber.	02320		

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02320	Continued From page 124 The licensee's Medication Management-Dosage Box Setup policy dated August 1, 2024, indicated a licensed nurse would set up resident dosage boxes timely and accurately. 144G.08, Subd. 41 Medication setup. "Medication setup" means arranging medications by a nurse, pharmacy, or authorized prescriber for later administration by the resident or by the facility staff. No further information was provided. TIME PERIOD TO CORRECT: IMMEDIATE On February 19, 2025, the licensee implemented actions to mitigate the risk to R5 and R6. Scope and severity remain at I.	02320		

Minnesota Department of Health
Food, Pools, and Lodging Services
12 Civic Center Plaza
Mankato, MN 56001
507-344-2700

Type: Full
Date: *02/19/25*
Time: 11:30:08
Report: 7990251002

Food and Beverage Establishment Inspection Report

Location:
Valleyview of Northfield
812 North Linden Street
Northfield, MN55057
Rice County, 66

Establishment Info:
ID #: 0008979
Risk: Medium
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Valleyview of Northfield, LLC

Phone #: 5076454126
ID #: 27597

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

REPLACE TORN DOOR GASKET ON BEVERAGE AIR REACH IN FREEZER.

Comply By: 03/19/25

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 at Degrees Fahrenheit
Location: 3 COMPARTMENT SINK
Violation Issued: No

Quaternary Ammonia: = 200 at Degrees Fahrenheit
Location: SANITIZER BUCKET
Violation Issued: No

Hot Water: = at 168 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: KELVINATOR REACH IN COOLER CHEESE
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: BEVERAGE AIR REACH IN COOLER CHEESE
Violation Issued: No

Type: Full
Date: *02/19/25*
Time: 11:30:08
Report: 7990251002
Valleyview of Northfield

Food and Beverage Establishment Inspection Report

Process/Item: Hot Holding
Temperature: 152 Degrees Fahrenheit - Location: RICE & SAUSAGE
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	1

JODI AND I DISCUSSED COOLING, BAREHAND CONTACT PREVENTION, AND NOROVIRUS PREVENTION.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 7990251002 of 02/19/25.

Certified Food Protection Manager: Jodi S. Heckmann

Certification Number: 35515 Expires: 08/09/27

Signed: Emailed
Establishment Representative

Signed: Beryn D. Dorhs
7990

651-201-4500
health.foodlodging@state.mn.us

Report #: 7990251002

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging Services
12 Civic Center Plaza
Mankato, MN 56001

No. of RF/PHI Categories Out	0
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 02/19/25
Time In 11:30:08
Time Out

Valleyview of Northfield	**Address** 812 North Linden Street	**City/State** Northfield, MN	**Zip Code** 55057	**Telephone** 5076454126
License/Permit # 0008979	**Permit Holder** Valleyview of Northfield, LLC	**Purpose of Inspection** Full	**Est Type**	**Risk Category** M

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item. Mark "X" in appropriate box for COS and/or R.

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

	Compliance Status		COS	R
	Supervision			
1	(IN) OUT	PIC knowledgeable; duties & oversight		
2	(IN) OUT N/A	Certified food protection manager, duties		
	Employee Health			
3	(IN) OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN) OUT	Proper use of reporting, restriction & exclusion		
5	(IN) OUT	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices			
6	(IN) OUT N/O	Proper eating, tasting, drinking, or tobacco use		
7	(IN) OUT N/O	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands			
8	(IN) OUT N/O	Hands clean & properly washed		
9	(IN) OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	(IN) OUT	Adequate handwashing sinks supplied/accessible		
	Approved Source			
11	(IN) OUT	Food obtained from approved source		
12	IN OUT N/A (N/O)	Food received at proper temperature		
13	(IN) OUT	Food in good condition, safe, & unadulterated		
14	IN OUT (N/A) N/O	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
15	(IN) OUT N/A N/O	Food separated and protected		
16	(IN) OUT N/A	Food contact surfaces: cleaned & sanitized		
17	(IN) OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	IN OUT N/A (N/O)	Proper cooking time & temperature		
19	IN OUT N/A (N/O)	Proper reheating procedures for hot holding		
20	IN OUT N/A (N/O)	Proper cooling time & temperature		
21	(IN) OUT N/A N/O	Proper hot holding temperatures		
22	(IN) OUT N/A	Proper cold holding temperatures		
23	(IN) OUT N/A N/O	Proper date marking & disposition		
24	IN OUT (N/A) N/O	Time as a public health control: procedures & records		
	Consumer Advisory			
25	(IN) OUT N/A	Consumer advisory provided for raw/undercooked food		
	Highly Susceptible Populations			
26	(IN) OUT N/A	Pasteurized foods used; prohibited foods not offered		
	Food and Color Additives and Toxic Substances			
27	IN OUT (N/A)	Food additives: approved & properly used		
28	(IN) OUT	Toxic substances properly identified, stored, & used		
	Conformance with Approved Procedures			
29	IN OUT (N/A)	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance. Mark "X" in appropriate box for COS and/or R. **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
		Safe Food and Water		
30	(IN) OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A (N/O)	Plant food properly cooked for hot holding		
35	IN OUT N/A (N/O)	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) Emailed **Date:** 02/19/25

Inspector (Signature) Bryn D. Dorhi