Electronically Delivered

June 29, 2026

Licensee
Valora Senior Living of Orono
2635 Kelly Parkway
Orono, MN 55356

RE: Project Number(s) SL36734017

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 29, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

factor.

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

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

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

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,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 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
	36734	A. BUILDING: _____ B. WING _____	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALORA SENIOR LIVING OF ORONO	2635 KELLY PARKWAY ORONO, MN 55356

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36734016-0 On May 26, 2026, through May 28, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 61 residents; 43 were receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 May 27, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain an effective infection control program to comply with acceptable health care, medical, and nursing standards for infection control, by not cleaning shared equipment, and not performing appropriate hand hygiene, for two of three employees (unlicensed personnel (ULP)-E and ULP-G). This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 510		

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0 510	Continued From page 4 The findings include: ULP-E ULP-E had a hire date of December 11, 2025. ULP-E's record contained documentation the employee had been trained and competency tested prior to being delegated with resident cares. On May 27, 2026, during continuous observation from 8:21 a.m., through 9:16 a.m., the surveyor observed ULP-E put on gloves without performing hand hygiene and prepare medications for R4, which included mixing MiraLax (stool softener) powder in water. Without removing gloves, ULP-E walked to memory care and placed R4's MiraLax mixture into the medication refrigerator and then removed ULP-E's gloves. Without performing hand hygiene, ULP-E applied gloves and assisted R17 with dressing, removed ULP-E's gloves, and documented services provided. Without performing hand hygiene or applying gloves, ULP-E applied Vanicream (moisturizer) to R18's back and assisted with securing R18's undergarment followed by hand hygiene and documenting services. ULP-E then assisted R19 with ambulation to R19's apartment and set-up supplies for R19's grooming needs. Without performing hand hygiene, ULP-E administered R4's oral medications, documented administration and performed hand hygiene. ULP-E then administered scheduled medications to R20, documented administration, and without performing hand hygiene, ULP-E prepared and administered medication to R19. On May 27, 2026, at 9:38 a.m., ULP-E stated ULP-E was trained to complete hand hygiene before and after caring for each resident,	0 510		

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0 510	Continued From page 5 between cares with the same resident, and between glove changes. ULP-E further stated ULP-E was trained to wear gloves where there was going to be any direct contact with a resident and with each medication pass. ULP-E stated, "[ULP-E] realize now [ULP-E] forgot hand hygiene sometimes." ULP-G ULP-G had a hire date of December 11, 2025. ULP-G's record contained documentation the employee had been trained and competency tested prior to being delegated with resident cares. On May 27, 2026, from 7:01 a.m., through 7:29 a.m., surveyor observed ULP-G go into R8's room apply gloves and remove a medicated patch from R8, applied a cream to R8's knee and then remove soiled gloves. ULP-G then went to the computer and documented the administration. At 7:21 a.m., ULP-G without preforming hand hygiene provided medication administration for R7. ULP-G then proceeded at 7:25 a.m., without preforming any hand hygiene, went on to administer medication to R16. After documentation of R16's medication administration, ULP-G took a hand sanitizer bottle out of the supply cabinet and opened the bottle and preformed hand hygiene for the first time since starting medication passes for the day. On May 27, 2026, at 8:22 a.m., ULP-G stated, "For cares you just put gloves on and when you take them off and wash hands, for meds we only wear gloves when we touch the meds and then use hand sanitizer. And we wash our hands when we are all done with our first rounds of meds." On May 28, 2026, at 9:32 a.m., clinical nurse	0 510		

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0 510	Continued From page 6 supervisor (CNS)-D stated, "That training is all done through Relias (an electronic training tool) and required when new employee starts and done annually, they should wash hands first, put gloves on, complete the cares, remove gloves, and wash hands." The Licensee's Hand Hygiene (Based upon the CDC Guideline Hand Hygiene in Healthcare Settings) policy, dated August 2025, indicated, "Hand hygiene may occur multiple times during a single care episode." and "When onducting a procedure requiring the use of gloves, proper hand hygiene shall be completed before donning gloves and after removing gloves." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 630 SS=F	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 self-abuse. This MN Requirement is not met as evidenced by:	0 630		

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0 630	Continued From page 7 Based on interview and record review the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of one independent residents (R6). 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: R6 was an independent resident and lived at the licensee's facility under the Licensee's contract beginning on December 11, 2024. R6's record lacked an individualized review or assessment of the resident's susceptibility to abuse by other individuals, and the specific measures to be taken to minimize the risk of abuse to the resident or other vulnerable adults and risk of self-abuse. On May 28, 2026, at 8:49 a.m., licensed assisted living director (LALD)-C stated, "As for the IAPP's that is on me, I told the staff I was going to get them done and I did not and I take responsibility for that, I have not done them, but I will get them done." The Licensee's Individual Abuse Prevention Plan policy, dated July 2021, indicated, "The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The	0 630		

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0 630	Continued From page 8 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 othervulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure residents' personal health and medical information was kept private for three of three residents (R7, R9 and R16). 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	0 700		

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0 700	Continued From page 9 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 May 27, 2026, from 7:25 a.m., through 7:34 a.m., surveyor observed unlicensed personnel (ULP)-G pass medications for R7, R9 and R16. ULP-G opened the resident record on a hand held charting device and dished up R7's medications, then walked away from the hand held device with it left open, and unsecured with R7's medical information on the screen to administer R7's medications. ULP-G then returned to the hand held device and charted the medication administration for R7. ULP-G then opened the resident record for R9 and dished up R9's medications, then walked away from the hand held device with it left open, and unsecured with R9's medical information on the screen to administer R9's medications. ULP-G then returned to the hand held device and charted the medication administration for R9. ULP-G then opened the resident record for R16 and dished up R16's medications, then walked away from the hand held device with it left open, and unsecured with R16's medical information on the screen to administer R16's medications. ULP-G then returned to the hand held device and charted the medication administration for R16. On May 27, 2026, at 8:27 a.m., ULP-G stated, "We are trained that you don't bring out your personal phone unless you call a coworker, we are to always log out of this charting system when we are not charting. I must have just forgotten today."	0 700		

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0 700	Continued From page 10 On May 28, 2026, at 9:32 a.m., clinical nurse supervisor (CNS)-D stated, "They are using hand held devices so they should go in document their completed tasks and then go out of the system. They should be keeping the hand helds on them." The Licensee's Client Record policy, dated July 2021, indicated, "To ensure compliance with the Comprehensive Home Care regulations: - Client records will be stored in a secure designated area. - Records will be stored in a locked cabinet accessible only by authorized staff." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		
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, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and	0 775		

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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
0 775	Continued From page 11 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May, 26, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in	0 810		

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	36734	A. BUILDING: _____ B. WING _____	05/29/2026

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0 810	Continued From page 12 their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May, 26, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.	0 810		

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0 810	Continued From page 13 TIME PERIOD FOR CORRECTION: Twenty One (21) days	0 810		
01350 SS=F	144G.60 Subd. 5 Temporary staff When a facility contracts with a temporary staffing agency, those individuals must meet the same requirements required by this section for personnel employed by the facility and shall be treated as if they are staff of the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure orientation to assisted living licensing and requirements was completed for all employees prior to providing services for one of one agency staff (unlicensed personnel (ULP)-H). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-H was contracted by the licensee on May 17, 2026, to cover and provide direct care services to residents of the assisted living facility. The licensee's staff schedule dated May 17, 2026, through May 23, 2026, indicated ULP-H was scheduled to cover and provide direct care services to the residents at the assisted living facility on May 17, 2026.	01350		

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01350	Continued From page 14 ULP-H's employee record lacked the following required assisted living orientation content: - overview of the 144G statutes - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure On May 28, 2026, at 3:08 p.m., licensed assisted living director (LALD)-C stated, "I have the stuff we orientated on with our agency staff from last night, because I called him in last night and knew he needed it, but I have nothing for any of the other [agency] staff we have used, there is no documentation. We do the trainings, and I can show you those trainings they are given, but the last person in this position has not gotten back to me where those files are stored."	01350		

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01350	Continued From page 15 The Licensee's Education policy dated September 2024, indicated, "Employees who provide seasonal work around their schooling (i.e. college students) will not be provided special considerations. They are required to keep up with education/training like all other employees." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01350		
01540 SS=F	144G.64 (a) (3) Training in Dementia, Mental Illness, and De- (3) for assisted living facilities with dementia care, direct-care staff must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, the staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter;	01540		

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01540	Continued From page 16 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct care staff received the required two hours of initial training on mental illness and de-escalation topics for one of one employee (unlicensed personnel (ULP)-E). 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: ULP-E was hired on December 11, 2025, to provide direct care services to the licensee's residents. On May 27, 2026, at 8:21 a.m., the surveyor observed ULP-E administer scheduled medications to R4. ULP-E's employee record lacked evidence of completing the required two hours of mental illness and de-escalation training. On May 28, 2026, at 8:48 a.m., licensed assisted living director (LALD)-C stated, "We found a flaw in the system, and we only have one hour for everyone." The Licensee's Dementia Training Requirements policy did not address the need for two hours of	01540		

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01540	Continued From page 17 mental illness and de-escalation training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A	01620		

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01620	Continued From page 18 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 assessments within 14-days following a residents admission date for two of three residents (R2 and R4). The licensee also failed to ensure the RN conducted ongoing nursing assessments not to exceed every 90-days thereafter for one of three residents (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 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).	01620		

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01620	Continued From page 19 The findings include: R2 R2 was admitted to the licensee and began receiving services on January 27, 2026. R2's record included a signed Assisted Living Contract dated January 27, 2026. On May 27, 2026, at 8:06 a.m., surveyor observed unlicensed personnel (ULP)-G provide medication administration to R2. R2's record included a pre-assessment nursing assessments dated January 27, 2026, and a change of condition assessment dated February 12, 2026, which indicated 16 days between assessments, and exceeded the 14 day requirement for assessment. R4 R4 was admitted to the licensee and began receiving assisted living services on May 11, 2026. R4's record included a signed Assisted Living Contract dated May 12, 2026. On May 27, 2026, at 8:21 a.m., the surveyor observed ULP-E administer scheduled medications to R4. R4's record included a pre-admission nursing assessment dated April 27, 2026. R4's record lacked any additional nursing assessments which indicated 16 days had passed since R4's initiation of services on May 12, 2026. R3	01620		

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01620	Continued From page 20 R3 was admitted and began receiving assisted living services on December 1, 2023. R3's record included a Residency Agreement signed by R3's legal representative on July 10, 2024 R3's record included a 90-day nursing assessments dated February 16, 2026, no other assessments had been completed by time of survey, indicating which indicated 99 days had passed since R3's last assessment. On May 26, 2026, at 10:45 a.m., during the entrance conference, clinical nurse supervisor (CNS)-D acknowledged they were the primary nurse responsible for completion of documentation and assessments of residents residing in the facility. CNS-D indicated licensee's expectation were: -an initial assessment would be completed prior to move in, another within 14 days of the initial assessment, as well as every 90 days, or with any change of condition. On May 27, 2026, at 1:30 p.m., CNS-D acknowledged the surveyor was given all assessments and there were no other assessments completed. On May 27, 2026, at 9:32 a.m., CNS-D stated, "We do a pre-assessment before they get here and once they move in we finish it and then 14 days and then 90." CNS-D acknowledged the assessments were not getting completed within the required time frame and stated it was because there was "not enough hours in the day" and stated, "Since bringing on another RN will make it a lot easier to get them completed on time."	01620		

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01620	Continued From page 21 The Licensee's Comprehensive Assessment Schedule policy, dated August 2022, indicated assessments would be completed withing 14 days after initiation of services as well as at least every 90 days. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) 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. (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	01640		

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01640	Continued From page 22 by: Based on observation, interview and record review, the licensee failed to ensure there was a service plan initiated to document agreement on the services to be provided for two of two resident (R2 and 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 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: R2 R2 was admitted to the licensee and began receiving assisted living services on January 27, 2026. R2's record included a signed Assisted Living Contract dated January 27, 2026. On May 27, 2026, at 8:06 a.m., surveyor observed unlicensed personnel (ULP)-G provide medication administration to R2. R4 R4 was admitted to the licensee and began receiving assisted living services on May 22, 2026. R4's record included a signed Assisted Living Contract dated May 22, 2026. R2 and R4's records lacked service plans.	01640		

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01640	Continued From page 23 On May 27, 2026, at 1:30 p.m., clinical nurse supervisor (CNS)-D stated, "No service plan and no other assessments for [R2]. On May 28, 2026, at 9:32 a.m., CNS-D stated, "Service plans are driven by your assessment and they need to be sent to the appropriate individual for signature. We want to complete it as soon as possible the expectations for me should be within the first week that the resident is here. We know this is an issue and we are trying to get through it and make sure everyone has a service plan." The licensee's Service Plan policy, dated September 2023, indicated, "All services provided to clients will be delivered after an assessment by an RN is completed, an up-to date Service Plan is signed by an RN and the client or the client's designated representative." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for	01730		

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01730	Continued From page 24 each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and maintain a current individualized medication	01730		

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01730	Continued From page 25 management record for each resident to include all required content for one of three residents (R4). This practice resulted in a level two violation (a violation that did not harm a client'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: R4 was admitted to the licensee and began receiving assisted living services on May 11, 2026. R4's diagnoses included congestive heart failure (chronic heart condition causing fluid retention), atrial fibrillation (rapid and irregular heart rhythm), chronic obstructive pulmonary disease (lung disease causing restricted airflow and breathing difficulties), anxiety, and major depressive disorder. On May 27, 2026, at 8:21 a.m., the surveyor observed unlicensed personnel (ULP)-E administer scheduled medications to R4. When ULP-E completed the rights of medication administration, ULP-E stated R4's hydrocortisone 1 percent (%) cream was stored in R4's room for independent use. R4's doctors orders signed April 28, 2026, indicated R4 received hydrocortisone 1% cream - applied to rectal area topically every morning and at bedtime for hemorrhoids.	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36734	A. BUILDING: _____ B. WING _____	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALORA SENIOR LIVING OF ORONO	2635 KELLY PARKWAY ORONO, MN 55356

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01730	Continued From page 26 R4's Medication Administration Record (MAR) dated May 1 through May 31, 2026, indicated R4 received hydrocortisone 1% cream two times daily from May 12 through May 27, 2026. R4's Pre Admission (sic) Nursing Assessment dated April 27, 2026, indicated R4's ability to know when to take each medication was not applicable and R4 was not able to apply topical ointments or creams. The assessment further indicated medications were ordered by the licensee's nursing staff, stored in a locked medication cart and were administered by licensee staff. R4's record lacked a medication management assessment to reflect self-administration of hydrocortisone 1% cream and independent storage. On May 28, 2026, at 9:32 a.m., clinical nurse supervisor (CNS)-D stated, "Anytime there is a change in medication, because that assessment hasn't been updated yet, that's why and yes, its late." The Licensee's Comprehensive Assessment Schedule policy, dated August 2022, indicated ongoing medication management reassessments would be completed when the resident presents with symptoms or other issues that may be medication related. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		

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	36734	A. BUILDING: _____ B. WING _____	05/29/2026

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VALORA SENIOR LIVING OF ORONO	2635 KELLY PARKWAY ORONO, MN 55356

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01880	Continued From page 27	01880		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to store prescription medication securely and permit only authorized personnel to have access for two of two medication carts located in the secured memory care unit. 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 May 27, 2026, at 7:01 a.m., surveyer observed ULP-G walk away from the unlocked medication carts in the memory care unit to go fill water containers. The keys to both medication carts were left on the cart. At 7:07 a.m., ULP-G came back to the medication carts and grabbed the keys, locked the carts, and acknowledged the carts had been left unattended and unsecured. On May 27, 2026, at 8:23 a.m., unlicensed personnel (ULP)-G stated "The creams for	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36734	A. BUILDING: _____ B. WING _____	05/29/2026

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VALORA SENIOR LIVING OF ORONO	2635 KELLY PARKWAY ORONO, MN 55356

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01880	Continued From page 28 [resident's] bottoms we leave them in the rooms and the aides doing the cares will put it on them later. We both chart it, we have an EMAR (electronic medication administration record) and services, so I will have to go look if it got done and then chart it." On May 28, 2026, at 9:32 a.m., clinical nurse supervisor (CNS)-D stated, "We have locked med carts, and they are to be locked at all times when they are not in the med cart and the individual that is passing meds is the only one that has keys to that med cart." The Licensee's Medication Management policy, dated September 2023, indicated, "Medications must be in securely locked and substantially constructed compartments and permit only authorized personnel to have access." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36734	A. BUILDING: _____ B. WING _____	05/29/2026

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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
01890	Continued From page 29 sensitive medications were dated when opened for medications in three of three medication carts with time sensitive medications. In addition, the licensee failed to monitor for expired medication in one of three medication carts. 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: TIME SENSITIVE MEDICATION On May 27, 2026, at 12:12 p.m., the surveyor observed the first-floor medication cart one with unlicensed personnel (ULP)-E and observed the following time sensitive medications with no open date: - R11's fluticasone proprionate (manages breathing difficulty, chest tightness, wheezing and coughing) 100 micrograms (mcg) diskus inhaler, with an unknown amount of medication remaining; and - R12's latanoprost (lowers pressure inside the eye) 0.005% ophthalmic solution, with an unknown amount of medication remaining. On May 27, 2026, at 12:20 p.m., the surveyor observed the first-floor medication cart two with ULP-E and observed the following time sensitive medication with no open date: - R13's Arnuity Ellipta (prevents and controls asthma symptoms) 50 mcg inhaler, with 28	01890		

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	36734	A. BUILDING: _____ B. WING _____	05/29/2026

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01890	Continued From page 30 actuations remaining. On May 27, 2026, at 12:26 p.m., the surveyor observed the second-floor medication cart with ULP-I and observed the following time sensitive medications with no open date: - R14 latanoprost 0.005% ophthalmic solution, with an unknown amount of medication remaining; and - R15's timolol maleate (lowers pressure inside the eye) 0.5% ophthalmic solution times two open bottles, with an unknown amount of medication remaining. On May 27, 2026, at 12:14 p.m., ULP-E stated licensee employees were not trained to write the date opened on time sensitive medications. EXPIRED MEDICATIONS On May 27, 2026, at 12:26 p.m., the surveyor observed the second-floor medication cart with ULP-I and observed the following expired medication: - R10's methocarbamol 750 milligrams (mg), unknown number of tablets remained, expired on January 19, 2026. On May 27, 2026, at 12:40 p.m., ULP-I stated nursing employees audited the medication carts monthly for expired medications. On May 28, 2026, at 9:32 a.m., clinical nurse supervisor (CNS)-D stated, "We get our 28-day cycle and we go through the carts and look for anything that is expired and destroy it. Eye drops, insulins, and other time sensitive medications, they should all be labeled with the date that they are opened, and then they should get pulled from the cart once they are expired. I will have to look into this."	01890		

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01890	Continued From page 31 The manufacturers instructions for fluticasone proprionate 100 mcg inhaler date January 2019, indicated the diskus inhaler was to be discarded eight weeks after opening the foil pouch. The manufacturers instructions for latanoprost 0.005% opthalmic solution dated September 2020, indicated a bottle of medication was to be disposed of six weeks after being opened. The manufacturers instructions for Arnuity Ellipta 50 mcg inhaler dated January 2019, indicated the inhaler was to be discarded six weeks after opening the foil tray or when the counter read zero, whichever came first. The manufacturers instructions for timolol maleate 0.5% opthalmic solution dated June 25, 2020, indicated any unused medication which remained four weeks after being opened was to be discarded. The Licensee's Medication Management policy, dated September 2023, indicated, "The expiration date of a product can change once it is opened." and "Licensed staff will be responsible for following the disposal procedures." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In	02170		

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02170	Continued From page 32 addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to conduct an evaluation for activities that addressed all provisions and failed to develop an individualized	02170		

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02170	Continued From page 33 activity plan based on the evaluation, for one of one residents (R1) who resided in the secured memory care unit. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee had an assisted living with dementia care license, effective August 1, 2021. R2 was admitted to the licensee and began receiving services on January 27, 2026. R2's record included a signed Assisted Living Contract dated January 27, 2026. R2's diagnoses included depression, memory difficulty, kidney disease, and hypertension. R2 resided in the memory care secured unit. On May 27, 2026, at 8:06 a.m., surveyor observed unlicensed personnel (ULP)-G provide medication administration to R2. R2's records lacked documentation of evaluation of the following: - past and current interests; - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to	02170		

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02170	Continued From page 34 participate; and - identification of activities for behavioral interventions On May 28, 2026 at 9:32 a.m., clinical nurse supervisor (CNS)-D stated, "I don't have one for him and I know we are probably missing others too." The Licensee's Community Life Activities policy, dated, May 2025, indicated, "Residents are assessed and noted of personal preferences in relation to daily activity." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		
02320 SS=F	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure unlicensed personnel (ULP)-G followed appropriate medication administration procedures. This practice resulted in a level two violation (a violation that did not harm a resident's health or	02320		

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02320	Continued From page 35 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-G had a hire date of December 11, 2025. ULP-G's record lacked documentation the employee had been trained and competency tested prior to being delegated medication administration. On May 27, 2026, at 7:15 a.m., surveyor observed ULP-G wash hands, enter R8's room, put on clean gloves and remove a medicated patch from R8 and then open a tube of Diclofenac cream and without measuring place an unknown amount into ULP-G's hand and then rub it into R8's right knee. On May 27, 2026, at 8:25 a.m., ULP-G stated, "We were told there was a tool, but I just do like a small portion, like a little goes a long way, so like a pea size. I've seen that tool, I don't know if anyone else has. I just do a glob on my finger; I never use that ruler. For the eye drops, I think we were taught you have to wait about a couple of minutes between them, and I guess I just get them done so I don't forget to do one." On May 28, 2026, at 9:32 a.m., clinical nurse supervisor (CNS)-D stated, "They all know different eye drops should be given five minutes apart. With the gels they have the little ruler, and they are taught to look at the order and measure the amount out, apply it remove gloves and wash hands."	02320		

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02320	Continued From page 36 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

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

Food & Beverage Inspection Report

Establishment Info

VALORA SENIOR LIVING OF ORONO
2635 KELLEY PARKWAY
Orono, MN 55356
Hennepin County
Parcel:

Phone:

License Info

License: HFID 36734

Risk:
License:
Expires on:
CFPM: Carlos Sanchez Poot
CFPM #: 58817; Exp: 5/13/2028

Inspection Info

Report Number: F8041261076
Inspection Type: Full - Single
Date: 5/27/2026 Time: 10:20 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 2
Delivery: Emailed

New Order: 5-500 Refuse and Recyclables
5-501.16C *Priority Level: Priority 3 CFP#: 54*
MN Rule 4626.1255C Provide a waste receptacle at each handwashing sink or group of handwashing sinks if disposable towels are used.
COMMENT: NO GARBAGE LOCATED BY MEMORY CARE KITCHENETTE HAND SINK.
Comply By: 5/27/2026 Originally Issued On: 5/27/2026

New Order: 6-300 Physical Facility Numbers and Capacities
6-301.11 *Priority Level: Priority 2 CFP#: 10*
MN Rule 4626.1440 Provide an adequate supply of hand soap at each handwashing sink or group of 2 adjacent handwashing sinks.
COMMENT: NO HAND SOAP AT ONE OF THE KITCHEN HAND SINKS. HAND SOAP WILL BE RESTOCKED TODAY.
Comply By: 5/27/2026 Originally Issued On: 5/27/2026

New Order: 6-300 Physical Facility Numbers and Capacities
6-301.14A *Priority Level: Priority 3 CFP#: 10*
MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands.
COMMENT: NO HANDWASHING SIGN AT THE BISTRO OR MEMORY CARE SERVICE AREA HAND SINK.
Comply By: 6/3/2026 Originally Issued On: 5/27/2026

Food & Beverage General Comment

Inspection was completed with the kitchen manager, Carlos Sanchez. Tesa Brown was the lead Health Regulation Division Nurse Evaluator.

This facility has a commercial kitchen on the main floor, a kitchenette in memory care, and a bistro used for happy hour/events.

*Memory care: facility is currently transporting meals on cart from the kitchen in chaffing dishes or iced containers and serving in the dining room. Any leftovers are discarded after service. Establishment is planning to install a pass through window and dishwasher in the kitchenette and start using the steam table for service. Submit plans to MDH for approval.

Discussed the following:
- Employee illness policy and logging requirements
- Reporting foodborne illness complaints to the health dept.
- Handwashing
- Date marking
- Glove-use and bare hand contact
- Proper food storage
-Vomit clean-up procedures
- Restrictions concerning serving a highly susceptible population

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

I acknowledge receipt of the Metro District Office inspection report number F8041261076 from 5/27/2026

Carlos Sanchez

Sarah Conboy,
Public Health Sanitarian Supervisor
651-201-3984
sarah.conboy@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

VALORA SENIOR LIVING OF ORONO
Orono
County/Group: Hennepin County

Inspection Info

Report Number: F8041261076
Inspection Type: Full
Date: 5/27/2026
Time: 10:20 AM

Food Temperature: Product/Item/Unit: chicken tortilla soup**; Temperature Process:** Cooking
Location: stove at 188 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: sliced tomato**; Temperature Process:** Cold-Holding
Location: prep cooler at 37 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: turkey**; Temperature Process:** Cold-Holding
Location: prep cooler at 36 Degrees F.
Comment:
Violation Issued?: No

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

Food Temperature: Product/Item/Unit: milk**; Temperature Process:** Cold-Holding
Location: upright cooler/memory care at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: whipping cream**; Temperature Process:** Cold-Holding
Location: 2 door cooler at 41 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

VALORA SENIOR LIVING OF ORONO
Orono
County/Group: Hennepin County

Inspection Info

Report Number: F8041261076
Inspection Type: Full
Date: 5/27/2026
Time: 10:20 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Greater Than** 160 Degrees F.
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
Location: memory care **Equal To** 400 PPM
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
Location: Prep Area **Equal To** 400 PPM
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Dispenser
Location: 3-Comp Sink **Equal To** 400 PPM
Comment:
Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL36734017	**Date:** 5/26/2026
Facility Name: Valora Senior Living of Orono	
Facility Address: 2635 Kelley Parkway, Orono, MN 55356	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

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

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

   Comments:

   The rated fire door separating the maintenance room from the corridor was propped open with a wedge that prevented the door from closing fully and latching properly. All fire doors should be maintained free of obstruction such that they are properly self-closing.

   The rated fire door separating the swift pines room from the corridor was propped open with a wedge that prevented the door from closing fully and latching properly. All fire doors should be maintained free of obstruction such that they are properly self-closing.

3. Fire detection and alarm systems, emergency alarm systems, gas detection systems, fire-extinguishing systems, mechanical smoke exhaust systems and smoke and heat vents shall be maintained in an operative condition at all times and shall be replaced or repaired where defective. [Minn. Stat. 144G.45 subd. 2; MSFC 901.6]

   Comments:

   There was visible oxidization and corrosion on and around components of the fire sprinkler system riser including on the backflow preventer/water control valve. The water shut off valve was significantly rusted and not maintained in proper condition. The sprinkler system riser was not properly maintained and showed evidence of water leaking from the system and staining on the floor around rusted

components. The sprinkler system riser should be inspected, and the defective components should be repaired or replaced and maintained in proper condition.

There was black plastic residue on the sprinkler head in the kitchen. Sprinkler heads should be maintained free from debris or residue that may disrupt their operation.

The fire alarm system horn strobes in the maintenance room and in the kitchen were obstructed by stored items. Stored boxes and supplies hid the devices from view. Obstructing stored items were removed during the survey by facility staff. Alarm devices should be maintained free of obstruction.

4. A means of egress shall be free from obstructions that would prevent its use, including the accumulation of snow and ice. Means of egress shall remain free of any material or matter where its presence would obstruct or render the means of egress hazardous. No combustible material storage is allowed in the corridors or exit stairs. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.3]

Comments:

The marked exit doors in the maintenance room were obstructed by custodial carts that were stored in front of the doors. Exit doors should be maintained readily accessible and free of obstruction.

The marked exit door leading out of the facility from near the kitchen area was not readily and safely operable. The concrete sidewalk was cracked and broken on the threshold of the door and was not stable to walk on. The exit door was marked as closed and duct tape was in place over the push bar of the door. The exit door should be returned to proper operation, and the egress path should be maintained free of obstruction.

☒ **TAG IDENTIFICATION: 0810**

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

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

Comments: The licensee failed to provide site-specific employee actions for fires or similar emergencies to the surveyor during the survey. General fire safety information was provided, but it was not relevant and accurate to the facility. The FSEP should include site-specific procedures for evacuation during fire or similar emergencies and be maintained so that it is accurate.