



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 21, 2023

Licensee
Valley Assisted Living
523 Arnold Avenue South
Thief River Falls, MN 56701

RE: Project Number(s) SL30224015

Dear Licensee:

On August 3, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the June 2, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script that reads 'Jessie Chenze'.

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

JMD



Protecting, Maintaining and Improving the Health of All Minnesotans

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June 28, 2023

Licensee
Valley Assisted Living
523 Arnold Avenue South
Thief River Falls, MN 56701

RE: Project Number(s) SL30224015

Dear Licensee:

On June 3, 2023, 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 April 20, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the April 20, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey completed on April 20, 2023, found not corrected at the time of the June 3, 2023, follow-up survey and/or subject to penalty assessment are as follows:

0250-Conditions-144g.20 Subdivision 1 - \$500.00

0780-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (1)

0820-Fire Protection And Physical Environment-144g.45 Subd. 2 (g)

The details of the violations noted at the time of this follow-up survey completed on June 3, 2023 (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 June 3, 2023, we identified the following violation(s):

1620-Initial Reviews, Assessments, And Monitoring-144g.70 Subd. 2 (c-E)

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 \$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.

IMPOSITION OF FINES:

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.

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 the MDH within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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 MDH 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. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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.

We urge you to review these orders carefully. If you have questions, please contact Jess Schoenecker at 651-201-3789.

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,

A handwritten signature in dark ink, appearing to read 'Jess Schoenecker', with a stylized, flowing script.

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 651-281-9796

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30224	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/03/2023
NAME OF PROVIDER OR SUPPLIER VALLEY ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 523 ARNOLD AVENUE SOUTH THIEF RIVER FALLS, MN 56701		
(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: Project SL30224 On June 2, 2023, through June 9, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on April 20, 2023. At the time of the survey, there were ten (10) residents: Ten receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued and issued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. 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 surveyors' 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 subd. 1, 2, and 3.		
{0 120} SS=C	144G.11 APPLICABILITY OF OTHER LAWS Assisted living facilities: (1) are subject to and must comply with chapter	{0 120}			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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{0 120}	Continued From page 1 504B; (2) must comply with section 325F.72; and (3) are not required to obtain a lodging license under chapter 157 and related rules. This MN Requirement is not met as evidenced by: No further action required.	{0 120}			
{0 250} SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman	{0 250}			

Minnesota Department of Health

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{0 250}	Continued From page 2 access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by developing and/or implementing current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	{0 250}			

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{0 250}	Continued From page 3 cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, identified, I certify I have read and understand the following: - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by authorizing agent (AA)-Q on May 31, 2022. The licensee had an assisted living license reissued on August 1, 2022, with an expiration date of October 30, 2023. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - conducting initial and ongoing resident evaluations and assessments of resident needs During interview on June 8, 2023, at 12:15 p.m., director of nursing (DON)-J indicated s/he was working on updating all the policies and procedures to meet the current regulations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	{0 250}			

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{0 470}	Continued From page 4	{0 470}			
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: No further action required.	{0 470}			
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	{0 480}			

Minnesota Department of Health

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{0 480}	Continued From page 5 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{0 480}		
{0 485} SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: No further action required.	{0 485}		
{0 490} SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements	{0 490}		

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{0 490}	Continued From page 6 (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: No further action required.	{0 490}			
{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	{0 510}			

Minnesota Department of Health

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{0 510}	Continued From page 7 compliance with this subdivision. This MN Requirement is not met as evidenced by: No further action required.	{0 510}			
{0 550} SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: No further action required.	{0 550}			
{0 580} SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that	{0 580}			

Minnesota Department of Health

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{0 580}	Continued From page 8 have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: No further action required.	{0 580}			
{0 630} SS=E	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: No further action required.	{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	{0 640}			

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{0 640}	Continued From page 9 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. This MN Requirement is not met as evidenced by: No further action required.	{0 640}			
{0 660} SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (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: No further action required.	{0 660}			

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{0 680}	Continued From page 10	{0 680}			
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff 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: No further action required.	{0 680}			
{0 730} SS=D	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	{0 730}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30224	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/03/2023
NAME OF PROVIDER OR SUPPLIER VALLEY ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 523 ARNOLD AVENUE SOUTH THIEF RIVER FALLS, MN 56701		
(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
{0 730}	Continued From page 11 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 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	{0 730}			

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{0 730}	Continued From page 12 (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: No further action required.	{0 730}			
{0 780} SS=A	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by:	{0 780}			

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{0 780}	Continued From page 13 Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so that actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. 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 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). Findings include: On facility tour with the Maintenance Director (M)-E on June 2, 2023, at approximately 11:00 a.m., it was observed that the smoke alarms in the apartment were not interconnected so that actuation of one alarm caused all alarms in the dwelling unit to actuate. This condition was discovered during the remodel of this unoccupied apartment as new detectors were installed, but upon testing verification, the wrong type of detector was found to have been purchased and installed. New detectors are on order from the supplier but have not arrived for installation. This deficient condition was visually verified by M-E accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	{0 780}			
{0 800} SS=C	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	{0 800}			

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{0 800}	Continued From page 14	{0 800}			
	(4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: No action required. Satisfactory improvements made.				
{0 810} SS=C	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) employee 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) Employees 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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{0 810}	Continued From page 15 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 employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No action required. Satisfactory improvements made.	{0 810}			
{0 820} SS=E	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	{0 820}			

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{0 820}	Continued From page 16 failed to provide required egress windows in numerous rooms within the assisted living area. This deficient condition had the ability to affect a portion of the staff and residents. This practice resulted in a level two distinct hazard 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). Findings include: On facility tour with Maintenance Director (M)-E on June 2, 2023, at approximately 11:30 a.m., it was observed that windows within the unoccupied assisted living area of Rooms 50 through 81, did not meet egress requirements. The windows measured 31 inches by 19 inches when fully opened for a total of 589 square inches. Windows used for egress purposes in sleeping rooms must not have less than 20 inches of height and 20 inches of width of openable area and not less than 648 total square inches in openable area. All windows must meet these requirements prior to a resident occupying the room. During discussion of this condition, M-E explained that the licensee is aware of the situation and is deciding on how to proceed for this major project. This deficient condition was visually verified by M-E accompanying on the tour. TIME PERIOD FOR CORRECTION: Twenty-one	{0 820}			

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{0 820}	Continued From page 17 (21) days.	{0 820}			
{0 900} SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: No further action required.	{0 900}			

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{0 950} SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: No further action required.	{0 950}			
{0 970} SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility	{0 970}			

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{0 970}	Continued From page 19 liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: No further action required.	{0 970}			
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	01620			

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01620	Continued From page 20 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) completed an ongoing resident reassessment that did not exceed 90 days as required for two of four residents (R6, R9). Additionally, the licensee failed to ensure the RN completed a comprehensive reassessment to include current information regarding bed assistive devices for 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 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: 90-DAY ASSESSMENTS R6 R6 admitted to licensee for services on April 11, 2022. R6's medical record included diagnoses of chronic obstructive pulmonary disease (COPD), and depression/anxiety. R6 received assistance with bathing, housekeeping, laundry, and medication and oxygen management. R6's record indicated the RN completed the most recent 90-day assessment on January 18, 2023 (51 days overdue).	01620			

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01620	Continued From page 21 R9 R9 admitted to licensee for services on November 22, 2022. R9's medical record included diagnoses of heart failure, hypertension (high blood pressure), chronic kidney disease stage three, weakness, and blindness in one eye. R9 received assistance with bathing, housekeeping, laundry, and medication management. R9's record indicated the RN completed the most recent 90-day assessment on February 27, 2023 (11 days overdue). RE-ASSESSMENT R10 R10 was admitted to licensee for services on October 15, 2021. R10's medical record included diagnoses of hypertension, deep vein thrombosis of lower extremity (blood clot), and depression/anxiety. R10 received assistance with medication and treatment management, bathing, laundry, and housekeeping. R10's Resident Notes dated April 18, 2023, indicated with permission R10's grab bar was removed due to disuse. R10's record indicated the RN completed the most recent RN assessment on June 3, 2023. The assessment under "ADL Needs," indicated for bed mobility, R10 used a grab bar. Under "Safety," RN indicated R10 had a standard bed frame with no assistive device attached. During interview on June 8, 2023, at 12:15 p.m.,	01620			

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01620	Continued From page 22 director of nursing (DON)-J stated there was conflicting information R10's RN assessment regarding bed assistive devices and confirmed R10 did not currently have any devices on the bed. DON-J stated the RN assessments were late and "cannot lie about it or deny that it was late." Additionally, DON-J stated s/he had a system in place to remind the licensee when the assessment was due to be completed. The licensee's RN Clinical Assessment policy last revised on June 2021, indicated RN assessments would be completed annually for all residents. The policy also indicated during the RN assessment, the RN would interview the resident, observe, and assess the resident. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620			
{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: No further action required.	{01880}			
{01890} SS=E	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	{01890}			

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{01890}	Continued From page 23 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: No further action required.	{01890}			
{01910} SS=D	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: No further action required.	{01910}			
{02040} SS=C	144G.81 Subdivision 1 Fire protection and physical environment	{02040}			

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{02040}	Continued From page 24 An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: No action required. Satisfactory improvements made.	{02040}			
{02110} SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an	{02110}			

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{02110}	Continued From page 25 assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: No further action required.	{02110}			
{02140} SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including: (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by: No further action required.	{02140}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30224	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/03/2023
NAME OF PROVIDER OR SUPPLIER VALLEY ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 523 ARNOLD AVENUE SOUTH THIEF RIVER FALLS, MN 56701			
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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 3, 2023

Licensee

Valley Assisted Living

523 Arnold Avenue South

Thief River Falls, MN 56701

RE: Project Number(s) SL30224015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 20, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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. The 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.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment.

The MDH may impose a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH

also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - \$3,000.00

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$3,000.00

The total amount you are assessed is \$6,000.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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 MDH 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. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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.

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,



Jessica Chenze, Supervisor
State Evaluation Team
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30224	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/20/2023
NAME OF PROVIDER OR SUPPLIER VALLEY ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 523 ARNOLD AVENUE SOUTH THIEF RIVER FALLS, MN 56701		
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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: SL#30224015 On April 17, 2023, through April 20, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 18 active residents; 11 whom were receiving services under the Assisted Living Dementia Care license. An immediate correction order was identified on April 18, 2023, at 1:20 p.m., issued for SL30224015, tag identification 2310. On April 19, 2023, at 12:43 p.m., immediacy of correction order 2310 was removed as confirmed by evaluation supervisor, however, non-compliance remains at a scope and level of I. An immediate correction order was identified on April 19, 2023, issued for SL30224015, tag identification 1290.		0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 000	Continued From page 1	0 000		
0 120 SS=C	144G.11 APPLICABILITY OF OTHER LAWS Assisted living facilities: (1) are subject to and must comply with chapter 504B; (2) must comply with section 325F.72; and (3) are not required to obtain a lodging license under chapter 157 and related rules. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the assisted living facility website and marketing information did not advertise the facility provided specialty in dementia care. This had the potential to affect all current and prospective residents. 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 potential to affect a large portion or all of the residents). The findings include: The facility currently held an Assisted Living with Dementia Care license.	0 120		

Minnesota Department of Health

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0 120	Continued From page 2 On April 17, 2023, at approximately 1:00 p.m., during the entrance conference, licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated they were familiar with the current assisted living laws and regulations. On April 19, 2023, at 7:21 a.m., the surveyors observed the sign outside the facility, with the writing "Valley Home Assisted Living & Memory Care". The licensee's website (www.valleymn.com copyright date 2019) advertised "Valley Assisted Living and Memory Care". On April 17, 2023, at 1:15 p.m., LALD-A stated last fall, late October 2022, they shut down the memory care unit, and added several residents went to a sister facility in town. In addition, LALD-A stated they did not advertise as providing memory care services, but the website probably did, since the person that developed the website was not releasing the rights to it. LALD-A also said the goal was to renovate and open back up for memory care. The licensee's Advertisement policy dated June 1, 2019, noted "The facility shall not use false, fraudulent or misleading advertising in the marketing services". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 120			
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a	0 250			

Minnesota Department of Health

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0 250	Continued From page 3 provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter;	0 250		

Minnesota Department of Health

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0 250	Continued From page 4 (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on April 17, 2023,	0 250		

Minnesota Department of Health

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0 250	Continued From page 5 at 1:08 p.m., licensed assisted living director (LALD)-A stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent RN-A, identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will	0 250			

Minnesota Department of Health

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0 250	Continued From page 6 use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - 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.	0 250			

Minnesota Department of Health

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0 250	Continued From page 7 - 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. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by authorizing agent (AA)-Q on May 31, 2022. The licensee had an assisted living license reissued on August 1, 2022, with an expiration date of October 30, 2023. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - conducting and handling background studies on employees; - conducting initial and ongoing resident evaluations and assessments of resident needs; - medication management; - infection control practices; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards. As a result of this survey, the following orders were issued 0120, 0250, 0470, 0480, 0485, 0490, 0510, 0550, 0580, 0630, 0640, 0660, 0680, 0730,	0 250			

Minnesota Department of Health

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0 250	Continued From page 8 0780, 0800, 0810, 0820, 0900, 0950, 0970, 1290, 1880, 1890, 1910, 2040, 2110, 2140, 2310, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents;	0 470		

Minnesota Department of Health

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0 470	Continued From page 9 (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the staffing schedule was posted with the required content. This had the potential to affect the licensee's current residents, staff and any visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an Assisted Living with Dementia Care license, was licensed for a bed capacity of 60 residents, and at the time of the survey had a census of 18 residents. On April 17, 2023, and April 18, 2023, the licensee's Daily Staffing form was posted just outside the nursing station near the front entrance. The form listed the date, census, and the unlicensed personnel (ULP) names and shift start and end times. It also listed the registered nurse (RN), licensed practical nurse (LPN), administrator, and on-call RN names, but lacked the work shifts including the days and hours worked.	0 470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30224	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/20/2023
NAME OF PROVIDER OR SUPPLIER VALLEY ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 523 ARNOLD AVENUE SOUTH THIEF RIVER FALLS, MN 56701		
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0 470	Continued From page 10 On April 18, 2023, at 3:40 p.m., licensed assisted living director (LALD)-A stated the nursing hours were not listed on the daily staffing forms. The licensee's Staffing Daily Posting policy dated reviewed October 20, 2021, noted the licensee would post the daily staffing schedule in a public area to be accessible by staff and residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and 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 included document titled, Food	0 480		

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0 480	Continued From page 11 and Beverage Establishment Inspection Report dated April 18, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480			
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the Assisted Living contract did not require any resident to include and pay for meals as part of their assisted living package fee for one of three residents (R9) and the licensee failed to post a menu a week in advance that was made available to all residents. This had the potential to affect all residents.	0 485			

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0 485	Continued From page 12 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 potential to affect a large portion or all of the residents). The findings include: CONTRACT The licensee's contract lacked an option for residents to opt out of payment for meals residents would not want. During the entrance conference on April 17, 2023, at approximately 1:00 p.m., licensed assisted living director (LALD)-A stated the licensee provided three meals per day to the residents. R9's Assisted Living With Dementia Care Service Contract dated January 3, 2023, noted "We offer the option to opt in or opt out of the meal program at the facility." It also had a box to check either "I will participate in the meal program at the facility. This includes snacks and three meals per day.", or "I will not participate in the meal program at the facility. I will supply and prepare all of my own meals and snacks. By selecting this option, you/your loved one will be responsible for all of your/their own meal and snack purchasing and preparation. If you select foregoing the meal plan, you will receive a monthly credit to your account for \$200.00." The contract had two sections for this option, with the second option for residents participating in public funding. On April 17, 2023, at 3:55 p.m., R9 stated the	0 485			

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0 485	Continued From page 13 food at the facility was not good. R9 also stated she does not go out for breakfast and makes a breakfast drink in her room. R9 was not sure if she had to pay for breakfast or not. On April 19, 2023, at 2:18 p.m., administrator (A)-F stated residents did not have the option to opt out of a meal, it was "all or none". MENU POSTING On April 17, 2021, at 2:56 p.m., during the facility tour with licensed assisted living director (LALD)-A, the surveyor observed an April 2023 a hot breakfast menu posted on the bulletin board in the open dining room area. The April 2023 calendar had breakfast items listed for the following dates: April 2, 4, 6, 10, 12, 16, 20, 24, and 25th. All other date boxes were blank. LALD-A stated she thought there was another menu posted outside of the nursing station. LALD-A brought the surveyor to the nursing station and no menu was posted. LALD-A stated no weekly menu was posted. On April 18, 2023, at 8:49 a.m., unlicensed personnel (ULP)-G stated she worked in the kitchen. ULP-G stated she had not had time to plan a weekly menu. ULP-G stated she just made sure there was enough food for the next day. The licensee's Food and Dining Service policy dated June 1, 2019, noted a menu would be available/posted for clients to view. Menus would be kept on file for the past three months. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 485		

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0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have daily programs of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs. This had the potential to affect all residents who were being provided services at 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 490			

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0 490	Continued From page 15 or has the potential to affect a large portion or all of the residents). Findings include: During the entrance conference on April 17, 2023, at 1:25 p.m., licensed assisted living director (LALD)-A stated the facility did not have an activity director and the staff were supposed to provide the activities for the residents. LALD-A stated a monthly activity calendar had been developed and was posted. On April 17, 2023, at 2:21 p.m., the surveyors toured the facility with LALD-A. On the bulletin board in the open dining room area was a large, laminated activity calendar for April 2023. The calendar included at least one scheduled activity except for Sunday April 2, 9, 16, 23, and 30th. The surveyor asked LALD-A for copies of the March and April activity calendars. On April 17, 2023, at 3:00 p.m., LALD-A stated the facility did not have an activity calendar for March and the April calendar reflected the above. LALD-A stated there were no activities scheduled for Sundays and she stated, "I can't tell you why we don't have any activities scheduled for Sundays." The licensee's Activities policy dated October 20, 2021, noted facility strives to provide valuable activities and life enrichment programs for residents with Alzheimer's disease or other dementias. The activities calendars will be developed with these noted interests to the best of their ability and within reasonable accommodations. The activities calendar will be posted and available in a [sic] accessible area to residents.	0 490			

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0 490	Continued From page 16 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 490			
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 ensure infection control standards were followed for one of two unlicensed personnel (ULP-C) during medication administration and one of one ULP (ULP)-C by disinfecting shared equipment in between resident use. 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	0 510			

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0 510	Continued From page 17 of the residents). The findings include: On April 18, 2023, at 6:42 a.m., the surveyor observed ULP-C log into the electronic record and start the medication administration process for R5. ULP-C did not complete hand hygiene prior to preparing R5's scheduled morning medications. Prior to leaving the medication cart ULP-C placed in her uniform pocket a pulse oximeter (a device that measures oxygen levels by utilizing a sensor attached to a finger) and an infrared thermometer. ULP-C entered R5's room; administered R5's scheduled medications; placed the pulse oximeter on R5's finger; and took R5's temperature. ULP-C returned to the medication cart, placed the pulse oximeter and thermometer on the medication cart and documented in R5's electronic record that his medications had been administered. The surveyor did not observe ULP-C perform hand hygiene or disinfect the pulse oximeter or thermometer. On April 18, 2023, at 6:50 a.m., directly following the above observation, the surveyor observed ULP-C to review R6's electronic record and start the medication administration process for R6. ULP-C did not complete hand hygiene prior to preparing R6's scheduled morning medications. Prior to leaving the medication cart ULP-C placed in her uniform pocket the pulse oximeter and thermometer. ULP-C entered R6's room; administered R6's scheduled medications; placed the pulse oximeter on R6's finger; and took R6's temperature. ULP-C returned to the medication cart, placed the pulse oximeter and thermometer on the medication cart and documented in R6's electronic record that her morning medications had been administered. The surveyor did not	0 510			

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0 510	Continued From page 18 observe ULP-C perform hand hygiene or disinfect the pulse oximeter or thermometer. On April 18, 2023, at 7:04 a.m., directly following the above observation, the surveyor observed ULP-C to review R1's electronic record and start the medication administration process for R1. ULP-C did not complete hand hygiene prior to preparing R1's scheduled morning medications. Prior to leaving the medication cart ULP-C placed the thermometer in her uniform pocket. ULP-C entered R1's room, administered R1's scheduled medications and took R1's temperature. ULP-C returned to the medication cart, placed the thermometer on the medication cart and documented in R1's electronic record that her morning medications had been administered. The surveyor did not observe ULP-C perform hand hygiene or disinfect the thermometer. On April 18, 2023, at 7:13 a.m., ULP-C stated she did not "clean" the pulse oximeter or thermometer between residents and stated she "should have". ULP-C stated she did not perform hand hygiene before or after R5, R6, and R1's medication administration process. ULP-C stated she was not aware this needed to be done. On April 18, 2023, at 7:55 a.m., clinical nurse supervisor (CNS)-B stated the expectation was for staff to disinfect reusable resident equipment between residents. At 7:58 a.m., CNS-B stated staff should be performing hand hygiene before and after each medication pass, and in between all resident cares. The licensee's Hand Hygiene policy dated December 1, 2020, noted hands must be washed thoroughly with antimicrobial soap and water in between providing services with clients.	0 510			

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0 510	Continued From page 19 The licensee's Medication Administration Oral policy dated June 1, 2019, noted the following procedure for oral medication administration: wash hands; check orders on the resident's medication administration record; introduce self and explain procedure; provide privacy as appropriate; watch client take medication; wash hands; and document administration. The licensee's Cleaning Equipment, Storage and Usage dated June 1, 2019, noted all equipment and all environmental and work surfaces must be cleaned immediately if visibly soiled, between use and/or as needed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for 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	0 550			

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0 550	Continued From page 20 Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to the grievance procedure. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee failed to post the grievance procedure. During the facility tour on April 17, 2023, at approximately 2:25 p.m., the surveyors observed the entry area, common areas, and dining area within the facility with licensed assisted living director (LALD)-A, and noted the grievance procedure was not posted. On April 17, 2023, at 2:57 p.m., LALD-A stated she thought the grievance procedure was posted, but was unable to locate it. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			

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0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity appropriate to the size and relevant to the type of services provided by the assisted living. This had the potential to affect all residents receiving assisted living 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) 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: During the entrance conference on April 17, 2023, at 1:55 p.m., the surveyor asked licensed	0 580			

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0 580	Continued From page 22 assisted living director (LALD)-A for the documentation of the licensee's quality management activities. LALD-A stated the facility had "several things in the works" but had not implemented anything yet. The licensee's Quality Management policy dated October 20, 2021, noted the home care provider shall engage in quality management program relevant to the type of services the home care provider provides. Documentation about quality management activity must be available for two years. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580			
0 630 SS=E	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: Based on observation, interview and record review, the licensee failed to ensure an individual	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30224	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/20/2023
NAME OF PROVIDER OR SUPPLIER VALLEY ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 523 ARNOLD AVENUE SOUTH THIEF RIVER FALLS, MN 56701		
(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
0 630	Continued From page 23 abuse prevention plan was developed to include the required content for two of two residents (R1, R2) with records reviewed. 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 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's diagnoses included diabetes, hypertension (high blood pressure) and chronic major depression. R1's service plan dated December 23, 2022, indicated the resident received services which included medication administration, blood glucose monitoring, behavior management, housekeeping, laundry, and assistance with bathing. On April 18, 2023, at 7:04 a.m., the surveyor observed unlicensed personnel (ULP)-C administer R1's scheduled morning medications and check R1's blood glucose level. R1's Individual Abuse Prevention Plan (IAPP) dated February 10, 2023, identified areas of vulnerability with interventions and a review of the resident's susceptibility to be abused by another individual, including other vulnerable adults. R1's IAPP did not include a review of the resident's risk of abusing other vulnerable adults.	0 630		

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0 630	Continued From page 24 R2 R2's diagnoses included hypertension and depression. R2's service plan dated January 1, 2023, indicated the resident received services which included medication administration, assistance with bathing, and assistance with dressing. On April 18, 2023, at 7:51 a.m., the surveyor observed ULP-C administer medications to R2 in the dining room. R2's IAPP dated February 27, 2023, identified areas of vulnerability with interventions and a review of the resident's susceptibility to be abused by another individual, including other vulnerable adults. R2's IAPP did not include a review of the resident's risk of abusing other vulnerable adults. On April 19, 2023, at 1:23 p.m., administrator (A)-F and licensed assisted living director (LALD)-A reviewed R1 and R2's IAPPs and stated there may be a problem with their electronic documentation system which was not prompting the review of a complete IAPP. A-F and LALD-A stated R1 and R2's IAPPs did not include a review of the residents' risk of abusing other vulnerable adults. 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	0 640		

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0 640	Continued From page 25 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment as required. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee failed to post information and the reporting number for the Minnesota Adult Abuse Reporting Center (MAARC).	0 640			

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0 640	Continued From page 26 During the facility tour on April 17, 2023, at approximately 2:25 p.m., the surveyors observed the entry area, common areas, and dining area within the facility with licensed assisted living director (LALD)-A, and noted the required information for MAARC was not posted. On April 17, 2023, at 2:59 p.m., LALD-A stated the information for MAARC had not been posted, and said the incorrect information for Department of Human Services (DHS) reporting had been posted instead. The licensee's Mandated Reporting-Vulnerable Adult policy dated June 2021, noted report suspected maltreatment of a vulnerable adult to MAARC at 1-844-880-1574, or online at https://mn.gov/dhs/report-abuse . 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 (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	0 660		

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0 660	Continued From page 27 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 observation, interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) including evidence of a two-step tuberculin skin test (TST) or other evidence of TB screening such as blood test for one of three 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: The licensee's facility TB risk assessment dated March 30, 2023, noted the TB risk level of the facility was low. ULP-C was hired to provide direct care and assisted living services on December 29, 2021. On April 18, 2023, at 7:51 a.m., the surveyor observed ULP-C administer medications to R2 in the dining room.	0 660			

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0 660	Continued From page 28 ULP-C's employee record contained a TST record, which indicated ULP-C had the first step TST administered on January 12, 2022, and read as negative on January 14, 2022. It also indicated ULP-C had the second step TST administered on January 14, 2022, the same day the first TST was read. The form noted if results were negative, the second step would be performed in one to three weeks. On April 19, 2023, at approximately 2:35 p.m., licensed assisted living director (LALD)-A stated the second step TST should not have been given the same date the first step TST was read. The licensee's Tuberculosis & Staff Screening policy dated October 22, 2021, noted the second step must be completed within three weeks of the first test. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated on the Baseline TB Screening Tool for HCWs Template (page 17), if results were negative, perform the second step in one to three weeks. 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:	0 680		

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0 680	Continued From page 29 (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff 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 and post a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, staff, and visitors of 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), 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	0 680		

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0 680	Continued From page 30 of the residents). The findings include: During the facility tour on April 17, 2023, at approximately 2:25 p.m., the surveyors observed the entry area, common areas, and dining area within the facility with licensed assisted living director (LALD)-A, and did not observe signage posted or information regarding the licensee's EPP. On April 17, 2023, at 2:55 p.m., LALD-A stated the EPP had never been posted at this facility. The licensee's EPP dated June 20, 2021, provided to the surveyor included vendor contact information, contact information for staff and community resources, a Hazard and Vulnerability Assessment Tool, and generic instructions for staff to follow in the case of a fire, severe weather, electrical/power outage, intruder/disruptive person, infectious disease-COVID-19, and an evacuation plan. The licensee's EPP did not include the following: The development of policies/procedures to address: - subsistence needs for staff and residents during an emergency to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal, emergency lighting, fire detection, extinguishing and alarm systems); - evacuation plan which included transporting services for residents being evacuated; - shelter in place; - a quarterly review of the missing resident policy (last review date June 2021); - development of arrangements with other facilities and providers to receive residents if needed; and	0 680		

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0 680	Continued From page 31 - the facilities role in providing care and treatment at alternative sites under a 1135 waiver A communication plan that included: - names and contact information for entities providing services under arrangement, resident physicians, other facilities, volunteers; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and - a method of sharing information from the EPP with residents and their families. On April 19, 2023, at 5:00 p.m. administrator (A)-F stated the EPP provided to the surveyors was basic. A-F stated she had been searching on her computer for supportive documents that needed to be added to the facility's EPP to make it more complete. A-F stated the EPP needed to be more complete and readily accessible for all staff. The licensee's Emergency Preparedness Program policy dated August 1, 2021, noted the EPP describes a facility's comprehensive approach to meeting the health, safety, and security needs of the facility, its staff, their resident population and community prior to, during and after an emergency or disaster. The program encompasses four core elements: 1. Emergency Plan that is based on a Hazard Vulnerability Assessment and incorporates an all-hazards approach; 2. Policies and Procedures; 3. Communication Plan; and 4. Training and Testing Program No further information was provided.	0 680			

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0 680	Continued From page 32	0 680		
	TIME PERIOD FOR CORRECTION: Twenty-One (21) days			
0 730 SS=D	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 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;	0 730		

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0 730	Continued From page 33 (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 ensure the resident record included a discharge summary with the required content 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 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 facility on December 1, 2021, and discharged to another assisted living facility on October 24, 2022. R4's diagnoses included hypothyroidism, hypertension, and diabetes mellitus type II. R4's service plan dated September 1, 2022,	0 730		

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0 730	Continued From page 34 noted services including medication administration, and assistance with bathing. R4's record lacked a discharge summary to include: - a summary of the resident's stay including diagnoses, course of illnesses, allergies, treatments and therapies, and pertinent lab, radiology, and consultation results; and - a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional status. On April 18, 2023, at 4:05 p.m., licensed assisted living director (LALD)-A stated the discharge summary with the required content had not been completed by the staff working at that time. The licensee's Resident Transfer/Discharge policy dated June 1, 2019, lacked information on a discharge summary or the required content. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730			
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes;	0 780			

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0 780	Continued From page 35 (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms outside and in the immediate vicinity of all sleeping rooms and failed to provide smoke alarms that are interconnected so that actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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). Findings include:	0 780		

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0 780	Continued From page 36 On facility tour with the Maintenance Director (M)-E on April 18, 2023, at approximately 11:30 a.m., it was observed that the smoke alarms in the apartment were missing. This condition was due to this apartment being unoccupied and under remodel, but no devices were evident for connection. With no devices available, the detectors also were not interconnected so that the actuation of one smoke alarm would cause the other alarms to actuate. These deficient conditions were visually verified by M-E accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation regarding the health, safety, comfort, and well-being of the residents. This deficient condition had the ability to affect a limited number of staff and residents.	0 800		

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0 800	Continued From page 37 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). Findings include: On facility tour with the Maintenance Director (M)-E, between approximately 9:00 AM and 11:30 AM on April 18, 2023, it was observed while standing in exit corridors that exit signs were not visible or illuminated. It is required that exit signs are visible at all times to ensure that exits are locatable in emergency events. This deficient condition was visually verified by M-E accompanying on the tour. Additionally, ceiling tiles throughout the facility had damage or were removed. Ceiling tiles must be maintained to prevent accidental failure and to ensure proper system operations within the facility. This deficient condition was visually verified by M-E accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping	0 810			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER VALLEY ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 523 ARNOLD AVENUE SOUTH THIEF RIVER FALLS, MN 56701		
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0 810	Continued From page 38 rooms; (2) employee 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) Employees 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 employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to complete required employee evacuation drills every other month and failed to complete fire safety and evacuation training at least twice per year. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a	0 810		

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0 810	Continued From page 39 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). Findings include: A record review and interview were conducted on April 18, 2023, at approximately 12:15 p.m. with the Administrator (Administrator)-F on the fire safety and evacuation plan, fire safety and evacuation training, and fire safety and evacuation drills for the facility. Record review of the fire safety and evacuation drills indicated that the licensee had performed fire drills but had not met the required number of drills. Records indicated that three drills had been performed with all being on the 1st of three shifts. This deficient condition was verified by Administrator-F during the interview. Record review of the available documents and interview for fire safety and evacuation training indicated that employees were trained initially upon hire, but no records were provided that showed training was provided at least twice per year thereafter. This deficient condition was verified by Administrator-F during the interview. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 820 SS=E	144G.45 Subd. 2 (g) Fire protection and physical environment	0 820			

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0 820	Continued From page 40 (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide required egress windows in numerous rooms within the assisted living area. This deficient condition had the ability to affect a portion of the staff and residents. This practice resulted in a level two distinct hazard 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). Findings include: On facility tour with Maintenance Director (M)-E on April 18, 2023, at approximately 10:30 a.m., it was observed that windows within an unoccupied	0 820		

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0 820	Continued From page 41 assisted living area did not meet egress requirements. The windows measured 31 inches by 19 inches when fully opened for a total of 589 square inches. After discussion and viewing other windows, Rooms 50 through 81 (totaling 31 rooms) in the assisted living area of the facility did not have windows that met the minimum requirements. Windows used for egress purposes in sleeping rooms must not have less than 20 inches of height and 20 inches of width of openable area and not less than 648 total square inches in openable area. All windows must meet these requirements prior to a resident occupying the room. These deficient conditions were visually verified by M-E accompanying on the tour and during interview by Administrator-F. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 820			
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a	0 900			

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0 900	Continued From page 42 complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a written contract, with the required content for seven of seven contracted staff (CS-J, CS-K, CS-L, CS-M, CS-N, CS-O, CS-P) residing in the "memory care" unit of 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) 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 April 17, 2023, at 3:10 p.m., the surveyors toured the facility with licensed assisted living	0 900		

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0 900	Continued From page 43 director (LALD)-A. Prior to entering the keypad access into the "memory care" unit LALD-A stated the licensee had five "travel" staff who were contracted to work at the licensee's other assisted living facility in town temporarily residing in the "memory care" unit (Housing Roster which was later provided by LALD-A included seven contracted staff members). CS-J had a start date of February 21, 2023. CS-K had a start date of March 24, 2023. CS-L had a start date of March 24, 2023. CS-M had a start date of March 27, 2023. CS-N had a start date of March 27, 2023. CS-O had a start date of March 28, 2023. CS-P had a start date of March 28, 2023. On April 17, 2023, at 4:40 p.m., LALD-A stated the licensee provided housing for the seven above noted contract staff. LALD-A stated she was unaware of the regulation that an assisted living may not provide housing to any individual unless it had executed a contract. On April 18, 2023, at 6:19 a.m., unlicensed personnel (ULP)-I stated the "travel" staff residing in the "memory care" unit do know the keypad code to enter and exit the "memory care" unit and occasionally come over to the unsecure unit to use the ice machine or if they forget their key. The licensee's Signing an Assisted Living Contract Policy dated October 20, 2021, noted when a prospective resident decides to move into	0 900		

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0 900	Continued From page 44 [name of facility] a signed Assisted Living contract should be signed and received by the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 900			
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated	0 950			

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0 950	Continued From page 45 representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of two residents' (R1, R2) assisted living contracts included a notice with the required verbiage for the residents to identify a designated representative. This had the potential to affect all residents who received services at the facility. 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 potential to affect a large portion or all of the residents). The findings include: R1 R1's service plan dated December 23, 2022, indicated the resident received services which included medication administration, blood glucose monitoring, behavior management, housekeeping, laundry, and assistance with bathing. R1's service plan included the name and contact information of R1's designated representative. R1's Assisted Living with Dementia Care Service Contract dated December 1, 2022, included the following statement "20. You may designate a representative to assist you. By making a designation in advance we can be certain that we deal with the person you have chosen to help you should a need arise. We ask that you provide	0 950		

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0 950	Continued From page 46 copies of any guardianship or conservatorship." R1's contract listed a "representative" (name no contact information). R2 R2's Assisted Living with Dementia Care Service Contract dated December 5, 2022, included the following statement "20. You may designate a representative to assist you. By making a designation in advance we can be certain that we deal with the person you have chosen to help you should a need arise. We ask that you provide copies of any guardianship or conservatorship." R2's contract listed a "representative" (name no contact information). R2's service plan dated January 1, 2023, indicated the resident received services which included medication administration, assistance with bathing, and assistance with dressing. R2's service plan included the name and contact information of R2's designated representative. R1 and R2's record lacked evidence of a notice with the required statutory language for the resident to have the opportunity to identify a designated representative. On April 18, 2023, at 4:04 p.m., licensed assisted living director (LALD)-A stated the Assisted Living with Dementia Care Service Contract was a template contract and was used for all residents at the facility. LALD-A stated section 20 of the assisted living contract did not contain all the language required as written in the statute regarding the resident's right to designate a representative. The licensee's Designated Representative policy dated April 2023, noted prior to, or at the time of	0 950			

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0 950	Continued From page 47 execution of an assisted living contract the licensee will discuss with the resident the Designated Representative section. The Designated Representative form must provide the following verbatim notice: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950			
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living	0 970			

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0 970	Continued From page 48 contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. 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). The findings include: The licensee's Assisted Living with Dementia Care Service Contract included a clause in which the resident would waive the facility's liability for personal property of the resident. Section 13. indicated the "Facility is not responsible for the safety or maintenance of personal property of the resident. Resident shall provide insurance on resident's personal property and bring to the facility at resident's sole risk. Facility accepts no responsibility for loss, damage, theft, or destruction of resident's personal property." On April 18, 2023, at 3:52 p.m., licensed assisted living director (LALD)-A stated the assisted living contract was a template contract and was used for all residents at the facility. LALD-A stated she was aware last fall this section of the contract needed to be updated. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970			

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01290	Continued From page 49	01290		
01290 SS=G	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure background studies were conducted prior to staff providing services, for one of five employees (unlicensed personnel/ULP-G). In addition, the licensee failed to ensure a background study was affiliated with the assisted living license for two of five employees (licensed assisted living director/LALD-A, clinical nurse supervisor/CNS-B). 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 an isolated scope (when one or a limited number of residents are affected or one or	01290		

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01290	Continued From page 50 a limited number of staff are involved or the situation has occurred only occasionally). This practice resulted in an immediate correction order on April 19, 2023, at approximately 9:45 a.m. The findings include: ULP-G ULP-G had a hire date of September 28, 2022. ULP-G's employee record lacked evidence of a completed background clearance letter. On April 17, 2023, and April 18, 2023, ULP-G was observed in the kitchen and the open dining area, setting the tables, and writing the menu on the white board, with residents in the dining area. No other staff person was observed in the area at those times. The licensee's untitled schedule from April 2, 2023, through April 29, 2023, indicated the following: - April 12, 2023, ULP-G was scheduled to work 6:00 a.m. to 2:00 p.m., training; - April 13, 2023, ULP-G was scheduled to work 6:00 a.m. to 2:00 p.m., training; - April 14, 2023, ULP-G was scheduled to work 8:00 a.m. to 12:00 p.m., dietary; - April 15, 2023, ULP-G was scheduled to work 6:00 a.m. to 2:00 p.m.; - April 16, 2023, ULP-G was scheduled to work 6:00 a.m. to 2:00 p.m.; - April 17, 2023, ULP-G was scheduled to work 6:00 a.m. (no stop time noted), dietary; - April 18, 2023, ULP-G was scheduled to work 7:00 a.m. to 2:00 p.m., dietary; - April 21, 2023, ULP-G was scheduled to work	01290			

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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
01290	Continued From page 51 7:00 a.m. to 2:30 p.m., dietary; - April 22, 2023, ULP-G was scheduled to work 6:00 a.m. to 2:00 p.m., (no other staff scheduled during this time); - April 23, 2023, ULP-G was scheduled to work 6:00 a.m. to 2:00 p.m., (no other staff scheduled during this time); - April 24, 2023, ULP-G was scheduled to work 7:00 a.m. to 2:30 p.m., dietary; - April 26, 2023, ULP-G was scheduled to work 6:00 a.m. to 2:00 p.m.; - April 27, 2023, ULP-G was scheduled to work 6:00 a.m. to 2:00 p.m.; and - April 28, 2023, ULP-G was scheduled to work 7:00 a.m. to 2:30 p.m., dietary. LALD-A LALD-A had a hire date of December 28, 2021. LALD-A's record lacked documentation of a background study affiliated with the facility's license. CNS-B CNS-B had a hire date of March 27, 2023. CNS-B's record lacked documentation of a background study affiliated with the facility's license. On April 18, 2023, at 9:04 a.m., ULP-G stated she works on the medication cart and provides cares to residents, but prefers to work in the kitchen. On April 19, 2023, at 8:03 a.m., licensed assisted living director (LALD)-A stated the licensee did not have a background study clearance letter for ULP-G yet, and stated ULP-G was currently on the schedule. Administrator (A)-F stated someone was "tethered" to ULP-G when she was	01290			

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01290	Continued From page 52 working. When asked to clarify tethered, A-F stated someone was present in the building, and there should be someone with her when she was passing medications. In addition, A-F stated when ULP-C was working, she would be the staff person with ULP-G. On April 19, 2023, at 8:06 a.m., ULP-C stated "for the most part" she had "oversight" of ULP-G when she worked, but she "checks in on" ULP-G when they were working together. ULP-C stated she normally worked in the office, so she was not always in sight of ULP-G. On April 19, 2023, at 10:30 a.m., LALD-A stated the background studies for LALD-A and CNS-B had not been affiliated with the licensee's HFID number prior to the initiation of survey on April 17, 2023. The licensee's Employee Required Documents policy dated revised March 22, 2022, noted the employee record must include documentation of the Minnesota required background study as required. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE Immediacy is removed as confirmed by evaluation supervisor on April 20, 2023, at 8:28 a.m., however, non-compliance remains at a scope and level of three, isolated (G).	01290			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and	01880			

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01880	Continued From page 53 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 ensure one of one medication refrigerator maintained an acceptable temperature and medications was stored according to manufacturer's recommended temperature. 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: On April 17, 2023, at 3:04 p.m., the surveyors toured the facility with licensed assisted living director (LALD)-A, including a review of the medication refrigerator in the locked medication room. LALD-A stated the current temperature of the medication refrigerator was 32 degrees Fahrenheit (F). LALD-A stated the medication refrigerator temperature should be checked twice a day and recorded on a paper log that should be posted on the front of the refrigerator. The surveyor asked for the March and April medication refrigerator temperature logs. LALD-A stated she didn't have any temperature logs for this refrigerator. The medication refrigerator contained four	01880		

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01880	Continued From page 54 unopened glargine (Lantus) 100 units/milliliter (ml) insulin syringes for R1. The manufacturer's instructions for Lantus insulin pens dated November 2018, indicated unopened pens should be stored in the refrigerator between 36 to 46 degrees F. Do not allow to freeze. The licensee's Storage of Medications policy dated June 1, 2019, noted medications would be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01890 SS=E	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 medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications for two of three residents (R5, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01890			

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01890	Continued From page 55 safety but had the potential to have harmed a resident's health or safety) 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 April 18, 2023, at 6:42 a.m., the surveyor observed unlicensed personnel (ULP)-C administer R5 his scheduled morning medications which included administration of R5's Symbicort 160/4.5 micrograms (mcg) inhaler (bronchodilator). R5's Symbicort inhaler did not have a label which indicated the date the inhaler had been removed from the foil pouch and the date the inhaler would expire. ULP-C stated R5's Symbicort inhaler was not labeled with a date when the inhaler had been put into use and the date the inhaler would expire. On April 18, 2023, at 6:50 a.m., the surveyor observed ULP-C administer R6 her scheduled morning medications which included administration of R6's Symbicort 160/4.5 mcg inhaler. R6's Symbicort inhaler did not have a label which indicated the date the inhaler had been removed from the foil pouch and the date the inhaler would expire. ULP-C stated R6's Symbicort inhaler was not labeled with a date when the inhaler had been put into use and the date the inhaler would expire. On April 18, 2023, at 7:16 a.m., clinical nurse supervisor (CNS)-B reviewed the contents of the medication cart and stated R5 and R6's Symbicort inhalers were not labeled with a date when the inhalers had been removed from their	01890			

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01890	Continued From page 56 foil pouches and the date the inhalers would expire. CNS-B stated all time sensitive medications should be dated with a date when opened and a date when they would expire. The manufacturer's guidelines for the Symbicort inhaler dated August 2019, directed for the inhaler to be discarded when the labeled number of inhalations had been used or within three months after removal from the foil pouch. The licensee's Medication Management Services - Time Sensitive Medications policy dated June 2021, noted time sensitive medications would be dated when opened, and expiration dates added according to pharmacy guidelines. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01910 SS=D	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	01910			

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01910	Continued From page 57 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 licensee failed to document in the resident's record the disposition of the medications as required for one of one resident (R4) upon discharge. 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: R4's record lacked documentation of the disposition of the medications 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. R4 discharged to another assisted living facility on October 24, 2022. R4's diagnoses included hypothyroidism, hypertension, and diabetes mellitus type II.	01910			

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01910	Continued From page 58 R4's service plan dated September 1, 2022, noted services including medication administration. On April 18, 2023, at 4:05 p.m., licensed assisted living director (LALD)-A stated disposition of medications documentation with the required content had not been completed by the staff working at that time. The licensee's Disposal of Medications, Disposition of Medications policy dated June 18, 2020, noted documentation would be kept for medications to include the name, strength, prescription number if applicable, quantity, to whom the medications were given or destroyed, the date of destruction or disposition, and names of staff and other individuals involved. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system	02040		

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02040	Continued From page 59 by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on April 18, 2023, at approximately 12:30 p.m. with the Administrator (Administrator)-F on the hazard vulnerability assessment for the physical environment of the facility. Record review indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During record review, it was noted that the licensee had performed a hazard assessment but had not performed a hazard vulnerability assessment for the physical environment on or around the property. This deficient condition was verified by Administrator-F during the interview. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

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02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced	02110			

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02110	Continued From page 61 by: Based on interview and record review, the licensee failed to develop and implement all required policies and procedures related to dementia care. In addition, the licensee failed to ensure the required dementia care policies and procedures were provided to each resident and/or the resident's legal and designated representatives. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The facility currently held an Assisted Living with Dementia Care license. The Special Unit Program's, Environment and Staff Credentials (For Licensed Assisted Living's with Dementia Care) policy dated February 1, 2022, did not address the following required policies and procedures: - evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed - wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes - medication management, including an assessment of residents for the use and effects of medications, including psychotropic	02110			

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02110	Continued From page 62 medications - limiting the use of public address and intercom systems for emergencies and evacuation drills only - transportation coordination and assistance to and from outside medical appointments; and - safekeeping of residents' possessions On April 18, 2023, at 4:00 p.m., licensed assisted living director (LALD)-A stated the above noted dementia care policies and procedures had not been developed as required. LALD-A stated the only dementia care policy that was provided to the resident and/or their representative was the Special Unit Program's, Environment and Staff Credentials (For Licensed Assisted Living's with Dementia Care) policy. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02110		
02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including: (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the	02140		

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02140	Continued From page 63 licensee failed to ensure the designated person overseeing staff training in the care of individuals with dementia (licensed assisted living director (LALD)-A), had documented evidence of competency or knowledge test required by the commissioner. This had the potential to affect all residents and staff of 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The facility currently held an Assisted Living with Dementia Care license. During the entrance conference on April 17, 2023, at 1:07 p.m., LALD-A stated the facility currently did not have anyone certified to oversee the dementia care training for staff. LALD-A stated the plan was for herself to complete the required training and certification however, LALD-A stated she had yet to complete the required training nor had obtained the certification. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02140			
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services	02310			

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02310	Continued From page 64 (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 the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R8) with a hospital bedrail, and for one of one resident (R1) with a consumer rail. 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: This resulted in an immediate correction order on April 18, 2023, at approximately 1:20 p.m. HOSPITAL-STYLE BEDRAILS R8's diagnoses included epilepsy, hypertension, and a compression fracture of spine. On April 17, 2023, at 3:50 p.m., the surveyor observed R8 in his room, watching television. R8's bed was observed to be a hospital bed with	02310		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30224	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/20/2023
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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
02310	Continued From page 65 bilateral quarter rails in the raised position. At this time, R8 stated he used them [bedrails] to turn and reposition himself in bed and to get up independently. R8 stated it was ok for the surveyor to wiggle the bedrails, and they were noted to have slight movement in and out from the mattress. R8 stated they were tight enough for him and he had no concerns with them. R8's Service Plan (Waiver) - Addendum to Contract dated effective October 31, 2022, note services including assistance with bathing, compression stockings, and medication administration. R8's Assessment As Of Date dated January 18, 2023, noted the resident was independent with bed mobility, transfers, and utilized a wheeled walker. It noted R8 was independent with toileting, had joint pain and decreased endurance / strength related to the compression fractures. It noted R8 had a history of seizure disorder which was controlled on medication, with no seizures since his admission to the facility. Under bed safety, the assessment noted R8 utilized a hospital bed, with the mattress original to the bed. It noted the bedrail met FDA guidelines. On April 18, 2023, at 9:50 am., licensed assisted living director (LALD)-A stated all information related to the bedrails was included in the nursing assessment provided. On April 18, 2023, at 10:15 a.m., clinical nurse supervisor (CNS)-B stated she had not completed a bedrail assessment since her hire date about three weeks ago. In addition, CNS-B stated she was not aware of the zones of entrapment and did not include any measurements.	02310			

Minnesota Department of Health

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02310	Continued From page 66 On April 18, 2023, at 12:46 p.m., the surveyors, LALD-A and CNS-B entered R8's room with his permission. R8's hospital bed had bilateral black metal bedrails in the raised position. The right side was against the wall. Both bedrails were securely affixed to the bed. The surveyors observed CNS-B measure the bedrails. The openings between the bars for zone 1 were 2 1/2 inches for the four horizontal openings on both ends, and 2 1/4 inches for the five vertical openings in the middle. The measurements between the bottom of the rail and the top of the mattress for zone 2, was zero inches. The measurements between the mattress and the bedrail for zone 3, measured 1 1/4 inches. The measurements under the rail, at the ends of the rail for zone 4, measured zero inches. R8's record lacked documentation of measurements to ensure the bedrails were consistent with the Food and Drug Administration (FDA) guidelines. Additionally, R8's record lacked evidence the bedrails were installed per manufacturer's guidelines, the intended purpose of the bedrails, whether there was an increased risk for entrapment, whether the bedrails acted as a restraint, whether the bedrails were securely attached to the bed, and the physical inspection for areas of entrapment, stability, and correct installation. ASSISTIVE DEVICE R1's diagnoses included diabetes, hypertension, and depression. On April 18, 2023, at 7:04 a.m., the surveyor observed R1 laying in bed in her room. R1's bed had a single upper U-shaped consumer purchased bedrail on the right side of the bed in	02310			

Minnesota Department of Health

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02310	Continued From page 67 the stationary upright position. R1 stated she used the bedrail to help her get out of bed and to move from side to side. R1's Service Plan (Waiver) dated December 23, 2022, indicated the resident received the following services: bathing, housekeeping, laundry, blood glucose monitoring, and medication administration. R1's assessment dated February 10, 2023, indicated R1 used adaptive equipment to transfer. R1 had a grab bar in place which was used for aiding in transferring to and from bed and turning and repositioning. R1's record lacked a comprehensive assessment of the use of the assisted device (bedrail), including installation and use of the device according to manufacturer's guidelines, lacked evidence of physical inspection of the bedrail and mattress for areas of entrapment, stability, and correct installation of the device, and lacked evidence the licensee referred to the Consumer Product Safety Commission (CSPC) for bedrail recall information. R1's record also lacked evidence of an individualized risk and benefit discussion with the resident or the resident's representative. The record lacked information related to interventions implemented by the licensee to mitigate the resident's risk for safety pertaining to the use of the bedrail. On April 18, 2023, at 12:26 p.m., CNS-B stated she was unaware R1 had a bedrail on her bed. CNS-B stated she was not familiar with how to determine if the bedrail has been recalled. CNS-B said she would look up the model number on the bedrail and "google it". CNS-B reviewed R1's record and stated R1's record lacked	02310			

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02310	Continued From page 68 documentation a risk and benefit statement had been provided to the resident and or resident's representative. CNS-B also stated R1's record lacked interventions to mitigate the risk of entrapment. On April 18, 2023, at 12:41 p.m., CNS-B measured R1's bedrail with the surveyor present. The inside of the U-shaped bedrail measured 18 ¼ inches wide and the measurement between the bedrail and the mattress was four inches. The bedrail was not securely attached to the bed however, was held in place by bars placed between the mattress and box spring which were the full length of the bed. The licensee's Siderails (Bedrails) policy dated revised March 2022, noted when the facility was aware a resident was utilizing a siderail or medical device on a bed, the facility would assess the use, educate the resident / responsible person, regarding the risks and benefits of the siderails and verify the siderail was utilized consistent with the manufacturer's directions. It noted the staff would determine the siderail is safe, defined by not being recalled, used consistent with the manufacturer's directions, installed securely and maintained in good operating condition (not wobbly or loose), and design was consistent with the FDA's recommended dimensional measurements to reduce entrapment. In addition, it noted if the device was not "safe" criteria, the resident /representative would be informed that their facility did not accept bedrails that were not FDA compliant, and staff would work with the resident to create a safe plan for bed safety, including helping with siderail selection if the resident chose to utilize siderails.	02310			

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02310	Continued From page 69 The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs), indicated "licensees should refer to individual manufacturer's guidelines for appropriate installation, maintenance and use. In addition, licensees should refer to the Consumer Product Safety Commission (CSPC) for the most up-to-date information related to portable bed side rail recall information." The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment with hospital beds, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. 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 United States Consumer Product Safety Commission (USCPSC) dated April 29, 2021,	02310		

Minnesota Department of Health

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02310	Continued From page 70 identified a recall involving adult portable bedrails that do not have safety retention straps to secure the bedrail to the bed frame to keep the bedrail from shifting out of place and creating a dangerous gap. This poses a serious risk for strangulation, entrapment, and death. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE Immediacy is removed as confirmed by evaluation supervisor on April 19, 2023, at 12:43 p..m., however, non-compliance remains at a scope and level of three, widespread (I).	02310			

Type: Full
Date: 04/18/23
Time: 10:45:52
Report: 8045231054

Food and Beverage Establishment Inspection Report

Page 1

Location:

Valley Assisted Living
523 Arnold Avenue S
Thief River Falls, MN56701
Pennington County, 57

Establishment Info:

ID #: 0018611
Risk: Medium
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Valley Assisted Living

Phone #: 2186813286
ID #: 53526

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.

2-100 Supervision

2-102.11DEFGHI

**** Priority 2 ****

MN Rule 4626.0030DEFGHI The person in charge must be able to demonstrate their knowledge to the inspector of the importance of the following food handling procedures to preventing foodborne disease: handwashing; avoiding cross contamination; avoiding hand contact with ready-to-eat foods; time and temperature requirements for safely refrigerating, hot holding, cooling, and reheating TCS food; hazards of eating raw or undercooked meat, poultry, eggs, and fish; food temperatures and cooking times required to safely cook TCS food including meat, poultry, eggs, and fish; foods identified as major food allergens and the symptoms of an allergic reaction; identification of critical control points in a food service operation and steps to be taken to ensure the points are controlled.

FOOD EMPLOYEE UNABLE TO ANSWER QUESTIONS ABOUT FINAL COOKING AND RE-HEATING TEMPERATURES AT TIME OF INSPECTION.

Corrected on Site

2-300 Personal Cleanliness

2-301.15

**** Priority 2 ****

MN Rule 4626.0080 Employees must wash their hands in a handwashing sink. Discontinue using the following sinks for handwashing: sinks used for food preparation or warewashing or a service sink or a curbed cleaning basin used for the disposal of mop water.

OBSERVED FOOD EMPLOYEE WASHING HANDS IN A SINK NOT DESIGNATED FOR HAND WASHING.

Corrected on Site

Type: Full
Date: 04/18/23
Time: 10:45:52
Report: 8045231054
Valley Assisted Living

Food and Beverage Establishment Inspection Report

Page 2

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

CFPM CERTIFICATE NOT POSTED AT TIME OF INSPECTION.

Comply By: 04/19/23

6-100 Physical Facility Construction Materials

6-101.11A1

MN Rule 4626.1325A1 Provide smooth, durable, and easily cleanable floor, wall and ceiling surfaces.

OBSERVED BARE CONCRETE OR MOSTLY UNFINISHED FLOORS IN BOTH WALK-IN COOLERS AND THE DRY STORAGE AREA.

Comply By: 04/18/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

OBSERVED UNDERSIDE OF SERVING COUNTER BROKEN AT TIME OF INSPECTION.

Comply By: 04/18/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.114AB

MN Rule 4626.1580AB Remove all items unnecessary to the operation or maintenance of the establishment and litter from the premises.

OBSERVED MULTIPLE DOMESTIC PIECES OF EQUIPMENT NOT USED BY THE FACILITY.

Comply By: 04/21/23

Surface and Equipment Sanitizers

Chlorine: = 100 at Degrees Fahrenheit

Location: DISH MACHINE

Violation Issued: No

Food and Equipment Temperatures

Process/Item: Walk-In Cooler

Temperature: 38 Degrees Fahrenheit - Location: GRAVY

Violation Issued: No

Process/Item: Upright Cooler

Temperature: 38 Degrees Fahrenheit - Location: MILK

Violation Issued: No

Process/Item: Cooking

Temperature: 190 Degrees Fahrenheit - Location: SHRIMP

Violation Issued: No

Type: Full
Date: 04/18/23
Time: 10:45:52
Report: 8045231054
Valley Assisted Living

Food and Beverage Establishment Inspection Report

Process/Item: Re-Heating
Temperature: 175 Degrees Fahrenheit - Location: SLOPPY JOE
Violation Issued: No

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		0	2	4

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

I acknowledge receipt of the inspection report number 8045231054 of 04/18/23.

Certified Food Protection Manager: MELISSA BERGMAN

Certification Number: FM111537 Expires: 06/15/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: Adam J. Bommersbach
Adam Bommersbach
Public Health Sanitarian
705 5th Street NW, Suite A
(218) 308-21
adam.bommersbach@state.mn.us