Electronically Delivered

March 19, 2024

Licensee
Valley View of Long Prairie Inc
1104 4th Avenue Northeast
Little Sauk, MN 56347

RE: Project Number(s) SL39843015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on March 1, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
Per 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 residents/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 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 Department of Health 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.

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

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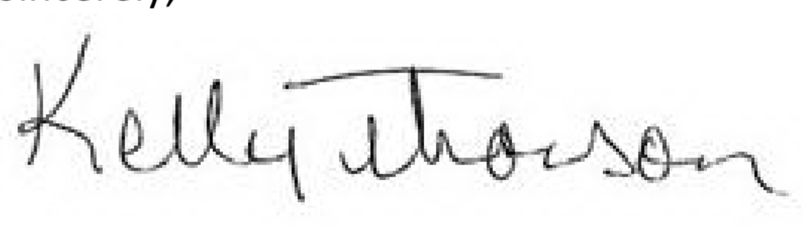
If you have any questions, please contact me.

Sincerely,



Kelly Throson , Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39843	A. BUILDING: _____ B. WING _____	03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW OF LONG PRAIRIE INC	1104 4TH AVENUE NORTHEAST LITTLE SAUK, MN 56347

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL39843015 On February 26, 2024, through February 28, 2024, 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 11 residents receiving services under the Assisted Living license.	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 Home Care 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 144A.474 SUBDIVISION 11 (b)(1)(2).	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure licensed assisted living director (LALD)-B was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. 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: On February 26, 2024, at 9:47 a.m., the Minnesota Board of Executives for Long-Term Services and Support (BELTSS) website indicated LALD-B currently held a LALD license effective through October 31, 2024; however, LALD-B's license failed to identify LALD-B as the Director of Record for the licensee. During the entrance conference on February 26, 2024, at 9:53 a.m., executive director (ED)-A stated they did not know they were not listed as director of record for licensee. On February 26, 2024, at 11:57 a.m., LALD-B	0 110		

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0 110	Continued From page 2 stated LALD-B did not finish the steps in applying for the director of record and was unable to give a reason why. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
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 document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 26, 2024, for the specific	0 480		

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0 480	Continued From page 3 Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 580 SS=C	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 implement and maintain a quality management program (QMP) appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current residents, staff, and visitors. 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	0 580		

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0 580	Continued From page 4 or has potential to affect a large portion or all of the residents). The findings include: On February 26, 2024, at 12:11 p.m., licensed assisted living director, (LALD)-B stated the licensee had not developed, implemented, or maintained any QMP due to being unaware of this requirement. The licensee's Quality Improvement policy dated May 1, 2023, indicated the licensee would have at least one documented quality improvement project in place and retain records of such projects for at least two years. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 660 SS=F	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.	0 660		

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0 660	Continued From page 5 (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included completion of a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test, for one of two employees (unlicensed personnel (ULP)-C). Additionally, the licensee failed to ensure TB symptom screening was completed at the time of hire for two of two employees (ULP-C, registered nurse (RN)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Facility TB Risk Assessment dated, February 1, 2023, indicated licensee's TB risk level was low. ULP-C ULP-C had a hire date of June 1, 2023, to provide direct care services to the licensee's residents. ULP-C's employee record contained a TB test on June 16, 2023, and was read five (5) days later June 21, 2023. ULP- lacked the forty-eight (48) to	0 660		

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0 660	Continued From page 6 seventy-two (72) hours after injection to read the TB test. ULP-C also lacked testing for the presence of mycobacterium tuberculosis by administering a two-step tuberculin skin test. Additionally, ULP-C's record lacked a Baseline TB Screening Tool for Healthcare Workers. RN-D RN-D had a hire date of May 15, 2023, to provide direct care services to the licensee's residents. RN-D's record contained a QuantiFERON test dated June 2, 2023, however; RN-D's record lacked a Baseline TB Screening Tool for Healthcare Workers. On February 27, 2024, at 10:47 a.m., director of nursing (DON)-E verified no additional TB information was available for ULP-C and RN-D. DON-E stated that RN-D had oversight of the licensee's staff TST and TB screening; DON-E was unable to determine why this was missed. The licensee's TST Protocol for Screening Health Care Workers dated May 1, 2023, indicated the nurse would implement the protocol for a two-step TST for all licensee's staff at the time of hire. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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	0 780		

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0 780	Continued From page 7 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: Based on observation and interview, the licensee failed to provide smoke alarms inside all sleeping rooms and interconnected smoke alarms in the facility. This had the potential to directly affect a limited number of residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).	0 780		

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0 780	Continued From page 8 Findings include: Interconnection On a facility tour on February 27, 2024, at 10:45 a.m., with executive director (ED)-A and licensed assisted living director (LALD)-B, it was observed that smoke alarms were not interconnected so activation of one alarm activates all alarms in resident sleeping unit number 104. There were alarms provided inside the sleeping room and outside the sleeping room in the sleeping unit but when tested the alarms were not interconnected. All sleeping units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the sleeping unit. During the tour the smoke alarms were tested and ED-A, and LALD-B, verified the smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility. Inside Sleeping Rooms On the same tour it was also observed that smoke alarms were not provided inside the sleeping room in sleeping unit number 120. Smoke alarms are required to be installed inside all sleeping rooms and outside in the immediate vicinity of the sleeping room within a sleeping unit. During the tour ED-A and LALD-B, verified smoke alarms were not installed inside the sleeping room in sleeping unit number 120.	0 780		

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0 780	Continued From page 9 TIME PERIOD FOR CORRECTION: One (1) day.	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 and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: On a facility tour on February 27, 2024, at 10:50 a.m., with executive director (ED)-A, and licensed assisted living director (LALD)-B, the surveyor	0 800		

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0 800	Continued From page 10 made the following observations of facility hazards and disrepair: A required exit light was tested and did not provide back up battery power upon activation of the test button in the corridor at the exit door near resident room number 121. Exit signs are required to be provided with emergency back up battery power according to Minnesota Fire Code in Minnesota Rules Chapter 7511. A required emergency light was tested and did not provide back up battery power upon activation of the test button in the corridor near resident room number 121 and 102. Emergency lighting is required to provide emergency backup battery power in the event of power failure in accordance with Minnesota Fire Code in Minnesota Rules Chapter 7511. Several light fixture covers were missing from light fixtures in the east and west corridor. Light fixtures are required to be maintained as installed and approved at the time of construction. The bathroom ventilation fan was not working when the power switch was turned on in resident room number 102. Bathroom ventilation fans are required to be maintained in operational condition as installed and approved at the time of construction. An electrical outlet cover was missing behind the reception desk near the ED-A, office. Electrical outlet covers are required to be maintained as installed and approved at the time of construction. An electrical extension cord was observed plugged in inside at the front entrance vestibule and routed outside under the exterior door.	0 800		

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0 800	Continued From page 11 Electrical extension cords are required to be only used for temporary power and shall not be routed through doorways that cause damage to the cord by opening and closing of the door. An orange electrical extension cord was observed fastened to an electrical conduit with zip ties and used as permanent wiring at the ceiling in the commercial kitchen near the exterior exit door. Electrical extension cords shall only be used as temporary use and not installed and attached to the building as permanent wiring. The commercial kitchen ventilation hood dry chemical fire suppression system was labeled as "non-compliant" by the fire suppression equipment service contractor. Commercial kitchen ventilation hood fire suppression systems are required to be maintained according to manufactures instructions and Minnesota Fire Code in Minnesota Rules Chapter 7511. The commercial kitchen ventilation hood system documentation of last duct cleaning was November 2022. Commercial kitchen ventilation hood system duct cleaning is required in intervals as required in Minnesota Fire Code in Minnesota Rules Chapter 7511. During a facility tour on February 27, 2024, at 11:00 a.m., ED-A, verified the above listed observations while 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	0 810		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW OF LONG PRAIRIE INC	1104 4TH AVENUE NORTHEAST LITTLE SAUK, MN 56347

(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
0 810	Continued From page 12 (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 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 observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide required	0 810		

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0 810	Continued From page 13 training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 27, 2024, at 10:10 a.m., executive director (ED)-A, and licensed assisted living director (LALD)-B, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. TRAINING Record review indicated the licensee failed to provided evacuation training to residents at least once per year as evident by not providing documentation the FSEP training had been provided annually to residents. Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year as evident by not providing documentation the FSEP training had been completed by employees as required. During an interview on February 27, 2024, at 10:25 a.m., ED-A, and LALD-B, stated documentation was not available for resident and employee training verification.	0 810		

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0 810	Continued From page 14 DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by providing documentation evacuation drills were completed July 5, 2023, at 1:10 p.m., and July 6, 2023, at 2:55 p.m., only. During an interview on February 27, 2024, at 10:30 a.m., ED-A and LALD-B, stated the only documentation available for drills completed were on July 5, 2023, at 1:10 p.m., and July 6, 2023, at 2:55 p.m. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01060 SS=C	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date	01060		

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01060	Continued From page 15 or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content to the resident, legal representative, and designated representative; and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39843	A. BUILDING: _____ B. WING _____	03/01/2024

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VALLEY VIEW OF LONG PRAIRIE INC	1104 4TH AVENUE NORTHEAST LITTLE SAUK, MN 56347

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01060	Continued From page 16 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included diabetes mellitus type 2. R1' service plan dated January 26, 2024, indicated resident received bathing once a week, blood sugar monitoring, morning dressing, medication assist, oxygen maintenance, skin checks, toileting, and transfer assist. R1's progress note indicated on December 21, 2023, at 1:50 p.m., "Resident went to Health System on 12/19/23 and was diagnosed with pneumonia." R1's progress note indicated on December 27, 2023, at 5:01 p.m., "Resident arrived at [licensee's name] around 3:10 p.m." R1's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident had been relocated and any new service provider; - contact information for the OOLTC; - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39843	A. BUILDING: _____ B. WING _____	03/01/2024

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VALLEY VIEW OF LONG PRAIRIE INC	1104 4TH AVENUE NORTHEAST LITTLE SAUK, MN 56347

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01060	Continued From page 17 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R1's record lacked notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days. On February 27, 2024, at 7:26 a.m., executive director (ED)-A, stated they did not provide the emergency relocation and notify the OOLTC. ED-A stated they had oversight and indicated they were aware of the requirements. ED-A stated they were unaware why this was missed. The licensee's Emergency Relocation and Notice policy dated August 1, 2021, indicated in the event of an emergency relocation the facility would provide a written notice as soon as possible to the resident, residents representative, designated representative and the office of ombudsman and resident's case manager. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by:	02310		

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02310	Continued From page 18 Based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for storage of oxygen. This had the potential to affect all 11 residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility license. The facility was licensed for a capacity of 22 residents and had a current census of 11 residents. On February 27, 2024, at 8:27 a.m. surveyor observed unlicensed personal (ULP)-C provide morning medications to R1 in R1's room. Surveyor noted one large used oxygen tank unsecured on R1's floor. On February 27, 2024, at 8:36 a.m., licensed assisted living director (LALD)-B and surveyor observed an empty room that contained R1's oxygen tanks. LALD-B stated R1's oxygen tanks are stored in the vacant room unsecured due to the vendor did not provide a secure container for the oxygen tank. LALD-B had shown surveyor 10 small oxygen tanks and 12 large oxygen tanks that were unsecured tanks dispersed on the carpet floor of the vacant room.	02310		

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02310	Continued From page 19 The licensee's Oxygen policy dated, May 1, 2023, indicated the licensee's nurse would manage the proper storage and upkeep of the resident's oxygen supplies. Minnesota Department of Health (MDH) internal document titled, Oxygen Cylinder Storage Requirements, dated April 16, 2020, which was based on the National Fire Protection Association, Standard 99 (NFPA 99), Health Care Facilities Code states: Volumes between 300 ft³ and 3000 ft³ of oxygen must be stored in special designated rooms that meet the following requirements: -Rooms must be non-combustible or limited-combustible construction (gypsum wallboard, tiled walls, etc.) with a door that can be secured from unauthorized entry (i.e. Locked). -Oxygen may not be stored with other flammable gases or liquids. -Oxygen cylinders must maintain a minimum distance of 20 ft. from combustibles (5 ft. if room is sprinklered), or placed within an enclosed cabinet having a fire rating of at least ½ hour. -Cylinders must be secured in racks or by chains. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

MN Department of Health
Food, Pools, and Lodging Services
PO Box 64975
St. Paul, MN 55164-0975
218-332-5150

Type: Full
Date: *02/26/24*
Time: 11:23:36
Report: 7935241004

Food and Beverage Establishment Inspection Report

Location:
Valley View Estates
1104 4th Avenue NE
Long Prairie, MN56347
Todd County, 77

Establishment Info:
ID #: 0042398
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/24

Operator:

Phone #:
ID #:

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.

3-500C Microbial Control: date marking

3-501.17A ***** Priority 2 *****

MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded.

MACARONI SALAD IN WALK IN COOLER. PIC PUT DATE MARK ON IT DURING INSPECTION.

Corrected on Site

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

PROVIDE INSPECTOR DATE ON WHEN FOOD SAFETY COURSE WILL BE TAKEN. APPLICATION FOR STATE CERTIFICATION EMAILED.

Comply By: 04/17/24

3-300B Protection from Contamination: cross-contamination, eggs

3-302.12

MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from orginal packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.

MACARONI SALAD. PIC PUT LABEL ON IT DURING INSPECTION.

Corrected on Site

3-500A Microbial Control: cooling

3-501.13ABC

MN Rule 4626.0380ABC Thaw TCS food by one of the following methods: 1. under mechanical refrigeration that maintains the food temperature at 41 degrees F (4 degrees C) or less; 2. completely submerged under running water at 70 degrees F (21 degrees C) or less with a velocity to remove loose particles on an overflow and the food is maintained at 41 degrees F (5 degrees C) or less; 3. in a microwave oven or; 4. as part of the cooking process.

RAW HAMBURGER WAS IN FOOD PREP SINK THAWING. HAMBURGER WAS STILL FROZEN AND PERSON IN CHARGE (PIC) MOVED IT TO WALK IN COOLER TO THAW.

Corrected on Site

4-600 Cleaning Equipment and Utensils

4-602.11E

MN Rule 4626.0845E Clean surfaces contacting food that is not TCS: 1. at any time when contamination may have occurred; 2. at least once every 24 hours for iced tea dispensers and consumer self-service utensils; 3. before restocking consumer self-service equipment and utensils such as condiment dispensers, and display containers; 4. at a frequency specified by the manufacturer or at a frequency necessary to preclude accumulation of soil or mold for ice bins, beverage dispensing nozzles, enclosed components of ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment.

CLEAN INSIDE AND OUTSIDE OF ICE MAKER. INSIDE ICE MAKER THERE WAS MOLD AND SCALE OBSERVED AND THE OUTSIDE OF THE MACHINE WAS DUSTY.

Comply By: 02/26/24

6-100 Physical Facility Construction Materials

6-101.11A1

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

KITCHEN CEILING HAS A POPCORN TEXTURE. CEILING NEEDS TO BE SMOOTH, SO THAT IT IS EASIER TO CLEAN.

Comply By: 12/31/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

CLEAN FLOOR IN WALK IN COOLER AND FREEZER (FOOD DEBRIS OBSERVED). CLEAN FLOORS UNDER AND BEHIND EQUIPMENT IN KITCHEN (FOOD AND DEBIS OBSERVED). CLEAN CEILING AND CEILING VENTS (DUST OBSERVED).

Comply By: 02/26/24

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: Spray Bottle
Violation Issued: No

Hot Water: = at 160 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cooking
Temperature: 186 Degrees Fahrenheit - Location: Chicken
Violation Issued: No

Process/Item: Cooking
Temperature: 203 Degrees Fahrenheit - Location: Potatoes
Violation Issued: No

Process/Item: Cooking
Temperature: 199 Degrees Fahrenheit - Location: Green Beans
Violation Issued: No

Process/Item: Cold Holding
Temperature: 34 Degrees Fahrenheit - Location: Walk In Cooler
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	1	6

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

I acknowledge receipt of the MN Department of Health inspection report number 7935241004 of 02/26/24.

Certified Food Protection Manager: NEED

Certification Number: _____ Expires: / /

Signed: _____
admin@valleyviewassistedliving

Signed: Rebecca Tonneson
Rebecca Tonneson
Public Health San Supervisor
Fergus Falls District Office
218-332-5142
rebecca.tonneson@state.mn.us