Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL302244642M
Compliance #: HL302249547C

Date Concluded: August 21, 2025

Name, Address, and County of Licensee Investigated:
Valley Assisted Living
523 Arnold Avenue South
Thief River Falls, MN 56701
Pennington County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Inconclusive

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The facility neglected the resident when it failed to immediately notify the registered nurse of a change in condition, resulting in a delay of care. The resident displayed stroke like symptoms when he woke up and reported it to an unlicensed personnel (ULP). The ULP failed to take action and the resident called his family, who brought him to the emergency room. The resident was diagnosed with a TIA (transient ischemic attack, often referred to as a mini stroke).

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Conflicting accounts of the incident were provided, and it was unable to be determined what symptoms were initially reported to staff by the resident. The resident was diagnosed with a TIA after his family brought him to the emergency room.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, hospital records, staff schedules, and related facility policy and procedures. Also, the investigator observed care and services provided at the facility.

The resident resided in an assisted living facility. The resident's diagnoses included history of stroke, high blood pressure, and atrial fibrillation (fast heart rate). The resident's service plan included assistance with reminders to meals and activities, medication administration, and daily pulse checks. The resident's assessment indicated the resident had a recent hospital stay for a TIA (mini stroke). The resident was independent with most activities of daily living however had impaired memory due to a past stroke.

The resident's record indicated he was hospitalized due to a stroke 28 days prior to the incident. The resident's record lacked documentation on what happened the morning the resident was taken to the emergency room and the only progress note related to the incident was entered after the nurse was made aware he had been taken in.

Hospital records indicated the resident woke up around 7:00 a.m. to use the bathroom but couldn't feel the left side of his body. The resident's symptoms had improved by the time he arrived in the emergency room around 9:45a.m. The resident was treated in the emergency room and discharged back to the facility later that afternoon.

During an interview, the resident was not able to recall specific events from the day he went to the emergency room.

During an interview, an unlicensed personnel (ULP) working that day stated she noticed the resident pushed his call light, which was unusual for him, and another ULP answered the light. The ULP stated she asked the other employee what the resident wanted since he didn't usually call for help and she reported that the resident said he was dizzy and needed help going to the bathroom. The ULP stated this was not normal for the resident, so she went in and checked his vital signs, which were all within normal limits. The ULP stated she asked the resident if he wanted to be sent into the emergency room and he declined. The ULP stated she told the resident if he felt dizzy again, he would have to go in. The ULP stated they did not notify the nurse because the resident's vital signs were normal, and the resident reported feeling better. The ULP stated she believed the resident may have had previous strokes but was not sure.

During an interview, the other ULP working that day stated she was not previously aware of the resident's history of stroke and had she known that, it would have changed how she responded to his symptoms. The ULP stated the resident had pushed his call light and told her he felt kind of "off", dizzy, and weak so she helped him get to the bathroom. Once he was in the bathroom, he reported feeling better. The ULP stated she gave the resident his call light and told him to push it if he needed help or wasn't feeling well again but he didn't use it and later she saw him up in the facility's sunroom. The ULP stated she recently started working at the facility so she

told her coworker about the resident's concerns as she wasn't completely sure what to do and the other ULP took his vitals and said it wasn't a big deal so she didn't do anything further regarding the resident's symptoms.

During an interview, the registered nurse (RN) stated she was not aware the resident wasn't feeling well or was sent to the emergency room until the resident's daughter called her that afternoon. The RN stated she later spoke with staff who reported the resident had been feeling dizzy but had normal vital signs, so she hadn't been called.

During an interview, the resident's daughter stated her aunt notified her that the resident contacted her to say he had another "spell" and didn't feel well. The resident's daughter stated she was concerned since the resident had a mini stroke a few weeks prior and had a stroke a few years ago, so she decided to bring the resident to the emergency room. The resident's daughter stated she called the facility RN later in the afternoon around 3 p.m. to update her on the resident and the RN wasn't aware that he was out of the building. The resident's daughter stated she told the RN that a staff member had answered her dad's call light that morning and despite it not being normal for him needing help to get out of bed, she got him out of bed and left him alone in the bathroom and didn't do anything else and given the resident's recent history of a stroke, she should have been notified. The resident's daughter stated the RN told her that the staff member who answered his light was new so she wouldn't know about his history, which she found upsetting as she felt that the staff member should know about the resident she is providing care for. The resident's daughter stated she was concerned that facility staff knew he wasn't feeling well, wasn't at lunch, and was out of the facility for several hours and facility staff hadn't noticed.

During an interview, the resident's sister stated the resident called her around 7:30 in the morning and she found that unusual for the resident. The resident's sister stated she spoke with the resident on the phone and he reported having an "episode," which caused her to be concerned. The resident's sister stated she tried calling the facility to see if someone could go check on him, but no one answered. She stated she called a second time and again no one answered, so she left a voicemail asking them to call her back regarding the resident, but no one ever called her back. The resident's sister stated she went to the facility and after talking with his daughter, it was decided they should bring him to the emergency room since he had a past history of strokes.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means neglect by a caregiver or self-neglect.

(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
No action taken.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30224	A. BUILDING: _____ B. WING _____	C 08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY ASSISTED LIVING	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 CORRECTION ORDER In accordance with Minnesota Statutes, section144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL302244642M/ #HL302249547C On August 5, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 16 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL302244642M/ #HL302249547C, tag identification 0630, 0775	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 1 (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 interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include a review/assessment of the person's ability to store unsecured firearms and ammunition in his room related to his cognitive status 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 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 a history of stroke, high blood pressure, and atrial fibrillation (fast heart rate). R1's service plan dated February 12, 2025,	0 630		

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0 630	Continued From page 2 indicated the resident received assistance with reminders to meals and activities, medication administration, and daily pulse checks. R1's assessment dated June 17, 2025, indicated the resident had impaired short term memory due to a previous stroke. However, the assessment lacked any assessment of the resident storing numerous unsecured firearms and ammunition in his room in relation to his impaired cognition or if any interventions had been attempted to encourage the resident to lock up his firearms or consider different storage of the firearms and ammunition. On August 5, 2025, the investigator asked R1 about the firearms observed in R1's room and asked where he stored the ammunition for the firearms. R1 stated he kept all his ammunition locked up away from the firearms. However, a table with at least 14 boxes of ammunition, was visible next to the resident. The resident demonstrated impairments with short term memory throughout the conversation with the investigator. On August 5, 2025, at 10:30 a.m., licensed assisted living director (LALD)-A stated she was aware the resident had firearms and ammunition in his room and that the family and county case manager were aware as well. LALD-A confirmed the resident's assessment lacked information on his ability to safely store and manage his firearms and ammunition and that they had not documented any conversations with the resident with their recommendations to lock the items up. On August 5, 2025, at 11:15 a.m., LALD-A observed the resident's room with the investigator and confirmed there were at least six visible,	0 630		

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0 630	Continued From page 3 unsecured firearms in the resident's room and likely at least a thousand rounds of ammunition in various containers throughout the room, as well as rifle primers. On August 6, 2025, at 1:50 p.m., clinical nurse supervisor (CNS)-B stated she was aware of the firearms in the resident's room and she would update the resident's assessment to reflect he had unsecured firearms and ammunition in his room. CNS-B stated she wasn't fully aware he had the number of ammunition and guns in his room that he did. On August 6, 2025, at 2:30 p.m., R1's daughter stated the resident had a stroke a few years ago and it impaired his memory. R1's daughter stated the resident was still very independent with activities of daily living and could still drive around town but had difficulties with his short term memory. R1's daughter stated the facility had reached out that morning to discuss safer storage options for the resident's firearms and ammunition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 775 SS=I	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced	0 775		

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0 775	Continued From page 4 by: Based on observation and interview, the licensee failed to comply with Minnesota State Fire Code in Minnesota Rules chapter 7511. This deficient condition had the ability to affect all staff, residents, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), 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: EGRESS WINDOWS On facility tour with construction consultant (CC)-R on July 15, 2025, at 2:30 pm., it was observed that the windows within the unoccupied assisted living area of rooms 50 - 81, did not meet egress requirements. The windows measured 31 inches W. by 19 inches H when fully opened for a total of 589 square inches. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to CC-R that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. During the discussion of this condition, CC-R explained that the licensee is aware of the situation and is	0 775		

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0 775	Continued From page 5 deciding on how to proceed for this major project. SMOKE ALARM MAINTENANCE: On facility tour with CC-R it was observed that the current smoke alarms were outdated. The surveyor observed the smoke alarms in the resident rooms were over 10 years old from date of manufacture. Smoke alarms over 10 years old from date of manufacture shall be replaced with like type alarms. Smoke alarms are required to be maintained with a manufacture date of ten years or less in accordance with MSFC in Minnesota Rules Chapter 7511. CC-R was aware of these outdated smoke alarms and would plan on replacing them. ELECTRICAL HAZARDS On August 5, 2025, at 10:30 a.m., the investigator observed that there was a portable space heater that was being powered through an extension cord. The plug end of the extension cord had been replaced from the original manufacturer plug end. Space heaters shall only be used in nonsleeping staff and employee areas. Extension cords shall be maintained in good condition without splices, deterioration or damage. AMMUNITION COMPONENTS STORAGE: On August 5, 2025, at 10:30 a.m., the investigator observed a 100-count box of large rifle primers on top of a folding table. The storage of black powder, smokeless	0 775		

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0 775	Continued From page 6 propellants, and small arms primers is prohibited. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 775		