DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 27, 2026

Licensee
Spring Valley Estates
815 Memorial Drive
Spring Valley, MN 55975

RE: Project Number(s) SL30563016

Dear Licensee:

On May 18, 2026, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on March 11, 2026. 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,

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

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March 27, 2026

Licensee
Spring Valley Estates
815 Memorial Drive
Spring Valley, MN 55975

RE: Project Number(s) SL30563016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 11, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

pursuant to this survey:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30563	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY ESTATES	815 MEMORIAL DRIVE SPRING VALLEY, MN 55975

(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: SL30563016-0 On March 9, 2026, through March 11, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 26 residents; 25 receiving services under the Assisted Living Facility with Dementia Care license. 1290: An immediate order was issued on March 9, 2026, at a level 3/Widespread (I). The licensee took action on March 9, 2026; however, the scope and level remain at I.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

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0 510	Continued From page 1 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 establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to glove use and handwashing by one of two unlicensed personnel (ULP-K) during blood sugar checks. 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). The findings include: On March 10, 2026, at 7:10 a.m., the surveyor observed ULP-K perform R7's blood sugar check and insulin injection. ULP-K washed her hands, donned clean gloves, and gathered blood sugar equipment (monitor, lancet, test strip). ULP-K	0 510		

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0 510	Continued From page 2 wiped R7's right middle finger, poked the finger to obtain a drop of blood and placed the drop of blood to the test strip in the blood sugar monitor. ULP-K stated R7's blood sugar reading was 161, disposed of the used test strip, and with the same gloves, documented the blood sugar reading on her tablet. ULP-K continued with the same gloves to obtain R7's Lantus insulin pen, wiped the pen tip, attached the pen needle, primed the pen with two units of insulin, wiped the abdomen with an alcohol wipe and injected the insulin to R7's abdomen. ULP-K continued with the same gloves and obtained R7's Novolog insulin pen, wiped the tip with an alcohol wipe, attached the needle, primed with two units of insulin, wiped R7's abdomen and injected the insulin. ULP-K returned the insulin pens to the locked medication cabinet and then removed the gloves. ULP-K did not remove the gloves and complete proper handwashing between the steps of blood sugar check and touching other surfaces (tablet, insulin pen, medication cabinet door). On March 10, 2026, at 11:25 a.m., the surveyor discussed the observation of the above-described blood sugar check process with ULP-K. ULP-K stated, "Now that you say that I do recall doing that. I will work on remembering to remove my gloves and sanitize my hands immediately following any contact with blood and before touching other surfaces." On March 10, 2026, at 1:25 p.m., clinical nurse supervisor (CNS)-B, stated her expectations were for all ULP to remove gloves and wash/sanitize their hands before touching any other surface, especially after completing a blood borne task such as a blood sugar check.	0 510		

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0 510	Continued From page 3 The licensee's Procedure for Using Gloves policy dated July 2023, indicated gloves are to be worn whenever there may be direct contact between the caregiver's hands and blood, body fluids, secretions, feces, or a contaminated item, such as soiled linens or wound dressings. Gloves will be removed carefully and disposed of in a proper container 1. Wash Hands 2. Apply gloves to both hands 3. Complete task. If gloves become torn or heavily soiled and additional tasks must be performed for the resident, then change the gloves (washing hands before putting on new gloves before starting the next task. 4. Place any contaminated materials in proper receptacle - such as biohazardous waste for wound care dressings. 5. Remove gloves by grasping cuff of one glove and pulling it off, turning it inside out. With ungloved hand, tuck finger inside cuff of remaining glove and pull it off, turning inside out with first glove inside the second glove. 6. Dispose of used gloves in proper receptacle - biohazardous if they have contaminated material on them. 7. Rewash hands. The licensee's Hand Hygiene policy dated July 2023, indicated Handwashing, which is the single most effective way of controlling the spread of infection, will be performed by staff routinely and thoroughly to protect residents from the spread of infection. No other information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		

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0 775	Continued From page 4	0 775		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 3/10/2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment	0 810		

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0 810	Continued From page 5 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota	0 810		

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0 810	Continued From page 6 Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 3/10/2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of	01060		

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01060	Continued From page 7 Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a written notice with required content for an emergency relocation for one of one resident (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	01060		

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01060	Continued From page 8 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: R10 began receiving services on May 19, 2023, with diagnoses including dementia, depression, chronic kidney disease, and bradycardia (low heart rate). R10's Service Plan dated June 6, 2023, included the services of medication management/administration, assistance with dressing, meal reminders, escorts to activities, and safety checks. R10's Service plan lacked the service of compression wraps. On March 10, 2026, at 2:00 p.m., the surveyor and unlicensed personnel (ULP)-K observed R10 resting in her bed. R10 was observed to be wearing her compression wraps on both lower extremities. ULP-K stated the compression wraps were put on in the morning and removed in the evening; however, R10 sometimes removed them on her own. R10's Resident Note dated February 21, 2026, indicated "Resident returned from hospital today at 4pm [sic] via family vehicle. New orders for compression wraps daily to bilateral lower extremities and hold memantine 10 milligrams [mg]. Medication list updated and family aware as they transported resident home." R10's After Visit Summary (AVS-known as a hospital discharge summary) dated February 21, 2026, indicated she was hospitalized from	01060		

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01060	Continued From page 9 February 19, 2026, through February 21, 2026, following a fall at the facility and noted bradycardia (low heart rate) and orthostatic hypotension (significant drop in blood pressure with changes in position). R10's record lacked a written notice for the hospitalization that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the residents may submit an appeal. On March 9, 2026, at 3:10 p.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated they were not aware of the emergency relocation requirement. The licensee's Contract Termination and Emergency Relocation policy dated August 2023, indicated in the event of an emergency relocation, the facility must provide a written notice that contains at minimum: The reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of	01060		

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01060	Continued From page 10 Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the residents may submit an appeal. The notice required will be delivered as soon as practicable to: a) the resident, legal representative, and designated representative; b) for residents who receive home and community-based waiver services under the resident's case manager; and c) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days.	01060		
01290 SS=I	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	01290		

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SPRING VALLEY ESTATES	815 MEMORIAL DRIVE SPRING VALLEY, MN 55975

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01290	Continued From page 11 section 13.02, subdivision 12. (c) Termination of a staff member 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 a background study was current and eligible on NETStudy 2.0 (web-based system for submitting background study requests to the Department of Human Services (DHS)) with the licensee for two of 20 employees (licensed practical nurse (LPN)-C, unlicensed personnel (ULP)-H). Furthermore, the licensee failed to ensure one of 20 employees (ULP)-I) was affiliated with the licensee's Health Facility Identification (HFID) 30563 as required. This had the potential to affect all residents. This resulted in an immediate correction order issued on March 9, 2026. 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: BACKGROUND STUDY CLEARANCE LPN-C LPN-C was hired on September 26, 2009, to	01290		

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01290	Continued From page 12 provide direct care services for the licensee's residents. On March 9, 2026, at 1:45 p.m., the surveyor observed LPN-C interacting with residents in the dining area of the secured memory care unit. LPN-C's employee file included a Minnesota Board of Nursing Licensed Practical Nurse license with an original issue date of July 24, 2015. On March 9, 2026, at 3:25 p.m., the surveyor received the licensee's NETStudy 2.0 roster printed March 9, 2026, and compared to the current employee roster; LPN-C was not found on the licensee's NETStudy roster. On March 9, 2026, at 3:30 p.m., director of human resources (DHR)-G stated LPN-C had a background study completed and affiliated with a previous home care license that has since closed. DHR-G further stated LPN-C should have had a new background study completed for this license. ULP-H ULP-H was hired on October 22, 1979, to provide direct care services. ULP-H employee file included a Background Study Clearance dated October 22, 1996. On March 9, 2026, at 3:35 p.m., the surveyor reviewed the licensee's NETStudy roster printed March 9, 2026, as compared to the current employee roster and noted ULP-H was not found on the NETStudy roster. On March 9, 2026, at 3:31 p.m., DHR-G stated	01290		

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01290	Continued From page 13 ULP-H had a background study completed and affiliated with a previous home care license that has since closed. DHR-G further stated ULP-H should have had another background study clearance completed and affiliated for this license. On March 9, 2026, at 4:10 p.m., licensed assisted living director (LALD)-A stated LPN-C and ULP-H had both been performing direct care duties without direct supervision. AFFILIATION ULP-I ULP-I was hired August 3, 2023, to provide direct care services for the licensee. ULP-I's employee record included a Background Study Clearance dated August 8, 2023, for HFID-121 (the licensee's associated Skilled Nursing Facility). ULP-I's NETStudy 2.0 website also showed a Background Study Clearance affiliated with HFID 121 and not with the licensee's HFID-30563. On March 9, 2026, at 3:50 p.m., DRH-G stated ULP-I should have been affiliated with HFID 30563; however, it was missed. On March 9, 2026, at 4:10 p.m., LALD-A stated ULP-I had direct contact with the licensee's residents without direct supervision. The licensee's Background Screening Investigations policy dated November 2010, indicated the Personnel/Human Resources Director, or other designee, will conduct employment background checks, reference	01290		

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01290	Continued From page 14 checks and criminal conviction checks (including fingerprinting as may be required by state law) on persons making application for employment with this facility. Such investigations will be initiated within two days of employment or offer of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The licensee took action on March 9, 2026; however, the scope and level remain at I.	01290		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve	01500		

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01500	Continued From page 15 when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of two employees (unlicensed personnel (ULP)-K).	01500		

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01500	Continued From page 16 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: ULP-K began providing direct care services on September 26, 2016, under the licensee's assisted living with dementia care license. ULP-K's employee record lacked evidence that the employee had successfully completed annual training to include review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases. On March 11, 2026, at 1:30 p.m. licensed assisted living director (LALD)-A stated she determined ULP-K had completed the Infection Control module through Educare (the licensee's online training program); however, ULP-K had "failed" the training/testing and LALD-A was not notified to reschedule the training. The licensee's Assisted Living with Dementia Care Annual Training for Unlicensed Personnel	01500		

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01500	Continued From page 17 policy dated August 2023, indicated the following training elements MUST be included every 12 months to all staff who perform direct care services; - review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the	01620		

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01620	Continued From page 18 resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed an accurate assessment of residents' condition/health status for one of three residents (R1).	01620		

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01620	Continued From page 19 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: On March 9, 2026, at 10:45 a.m. during entrance conference, clinical nurse supervisor (CNS)-B stated the registered nurses (RN) completed assessments at the time of admission, within 14 days following resident admission, and every 90 days. She further stated the RN completed comprehensive assessments for a resident's change in condition with resident changes, hospitalizations, and hospice enrollments. R1 began receiving services on December 27, 2022, with diagnoses including late onset Alzheimer's disease, anxiety disorder, and COPD (chronic obstructive pulmonary disease-a chronic lung disease). R1's Service Plan dated March 29, 2024, included the services of medication management/administration, bathing assistance, behavior management, grooming meal reminders, and safety checks. The Service Plan lacked services to include assistance with dressing, toileting, oxygen saturation checks, and oxygen management. On March 10, 2026, at 7:40 a.m., the surveyor observed unlicensed personnel (ULP)-J assist R1	01620		

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01620	Continued From page 20 out of bed, escort R1 to the bathroom, assist with toileting, complete an incontinence brief change and assist R1 to get dressed for the day. The surveyor also observed an oxygen concentrator and multiple portable oxygen cylinders in R1's room. ULP-J stated the staff checked R1's oxygen saturations three times daily and were to provide oxygen with low saturations. R1 only used oxygen as needed (PRN). R1's record included a signed order dated March 21, 2025, for oxygen that indicated "continuous oxygen at 4 liters/minute with exertion and 2 liters/minute while at rest. R1's record included a physician's visit note dated March 25, 2025, which indicated due to increased incidences of nose bleeds, and current stable oxygen levels, Oxygen changed from continuous to as needed (PRN) with facility staff to continue to monitor for decreased oxygen saturation levels. R1's Service Recap Summary (used as documentation of services received) dated March 2026, included the services of safety checks (12 times/day), grooming (a.m./p.m.), oxygen saturation checks (three times daily), toileting assistance (four times daily), dressing assistance (a.m./p.m.), meal reminders, and medication administration. R1's registered nurse (RN) assessments dated July 3, 2025, October 7, 2025, and January 5, 2026, indicated R1 needed moderate assistance to dress or undress, was incontinent of bladder and required staff assistance with incontinent products and peri-care. The assessments also indicated "no special respiratory equipment" and lacked any indication R1 had respiratory concerns	01620		

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01620	Continued From page 21 other than COPD and failed to indicate R1's need/use of oxygen. The licensee failed to accurately depict R1's respiratory changes to include any symptoms of shortness of breath, low oxygen saturations, nor the new need for oxygen. On March 11, 2026, at 1:35 p.m., CNS-B stated she had not identified R1's use of oxygen on any assessment completed since May 2025, and did not know how she missed it, knowing she helped bring in the equipment when it started. The licensee's Initial and On-going Assessments of Residents policy dated July 2023, indicated The RN will re-assess each resident on an on-going basis. At these re-assessments, the RN will: i. Review the resident's service plan ii. Evaluate the resident's medication management services and the resident's medications iii. Evaluate the residents' treatments, if any iv. Communicate any new problems or concerns to the resident's physician or health care providers, and v. Update the service plan as necessary based on the residents' needs No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date	01640		

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01640	Continued From page 22 that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was revised and signed by the resident or resident representative to reflect the current services provided for one of three residents (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).	01640		

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01640	Continued From page 23 The findings include: R1 began receiving services on December 27, 2022, with diagnoses including late onset Alzheimer's disease, anxiety disorder, and COPD (chronic obstructive pulmonary disease-a chronic lung disease). On March 10, 2026, at 7:40 a.m., the surveyor observed unlicensed personnel (ULP)-J assist R1 out of bed, escort R1 to the bathroom, assist with toileting, complete an incontinence brief change and assist R1 to get dressed for the day. The surveyor also observed an oxygen concentrator and multiple portable oxygen cylinders in R1's room. ULP-J stated the staff checked R1's oxygen saturations three times daily and were to provide oxygen with low saturations. R1 only used oxygen as needed (PRN). R1's registered nurse (RN) assessments dated July 3, 2025, October 7, 2025, and January 5, 2026, indicated R1 needed moderate assistance to dress or undress, was incontinent of bladder and required staff assistance with incontinent products and peri-care. R1's Service Recap Summary (used as documentation of services received) dated March 2026, included the services of safety checks (12 times/day), grooming (a.m./p.m.), oxygen saturation checks (three times daily), toileting assistance (four times daily), dressing assistance (a.m./p.m.), meal reminders, and medication administration. R1's Service Plan dated March 29, 2024, included the services of medication management/administration, bathing assistance,	01640		

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01640	Continued From page 24 behavior management, grooming meal reminders, and safety checks. R1's Service Plan lacked the services of Oxygen management, oxygen saturation monitoring three times daily, and full assistance with dressing and toileting. On March 11, 2026, at 11:30 a.m., clinical nurse supervisor (CNS)-B stated R1's Service Plan should have been updated to include the treatment of oxygen, and the change in services to include moderate assistance with dressing and toileting. The licensee's Contents of Service Plans policy dated August 2023, indicated a service plan is developed by the Registered Nurse based upon the uniform assessment. The RN provides a copy and reviews the plan with the resident/resident representative. Upon review the resident/resident representative signs the service plan documenting agreement of the services to be provided. Signatures may include email/verbally documented consent. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services	01940		

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	30563	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY ESTATES	815 MEMORIAL DRIVE SPRING VALLEY, MN 55975

(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
01940	Continued From page 25 that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to include on the service plan a written statement of the treatment or therapy services for two of three residents (R1, R10), and further failed to ensure the registered nurse (RN) specified, in writing, specific instructions and documented those instructions in the resident record for one of three residents (R1) with treatments/delegated tasks. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01940	Continued From page 26 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: During the entrance conference on March 9, 2026, at 10:45 a.m., clinical nurse supervisor (CNS)-B confirmed the licensee provided treatment and therapy services to residents as prescribed. R1 R1 began receiving services on December 27, 2022, with diagnoses including late onset Alzheimer's disease, anxiety disorder, and COPD (chronic obstructive pulmonary disease-a chronic lung disease). R1's Service Plan dated March 29, 2024, included the services of medication management/administration, bathing assistance, behavior management, grooming meal reminders, and safety checks. The Service Plan lacked oxygen management. On March 10, 2026, at 7:40 a.m., the surveyor observed unlicensed personnel (ULP)-J assist R1 out of bed, escort her to the bathroom, assist with toileting, complete an incontinence brief change and assist R1 to get dressed for the day. The surveyor also observed an oxygen concentrator and multiple portable oxygen cylinders in R1's room. ULP-J stated the staff checked R1's oxygen saturations three times daily and were to provide oxygen with low saturations. R1 only used	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01940	Continued From page 27 oxygen as needed (PRN). R1's record included a signed order dated March 21, 2025, for oxygen that indicated "continuous oxygen at 4 liters/minute with exertion and 2 liters/minute while at rest." R1's record included a physician's visit note dated March 25, 2025, which indicated due to increased incidences of nose bleeds, and current stable oxygen levels, Oxygen changed from continuous to as needed (PRN) with facility staff to continue to monitor for decreased oxygen saturation levels. R1's medication record (MAR) dated March 2026, and Service Recap Summary dated March 2026, lacked documentation of R1's PRN Oxygen use or tubing changes. On March 11, 2026, at 1:35 p.m., CNS-B stated she had not included R1's use of oxygen or staff monitoring oxygen saturations on any assessment completed since May 2025, and did not know how she missed it, knowing she helped bring in the equipment when it started. The licensee failed to update R1's Service Plan to include management of R1's PRN oxygen use. The licensee failed to provide written instruction regarding management of R1's oxygen use, in what the ULP should monitor for and report to nursing. R10 R10 began receiving services on May 19, 2023, with diagnoses including dementia, depression, chronic kidney disease, and bradycardia (low heart rate).	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01940	Continued From page 28 R10's Service Plan dated June 6, 2023, included the services of medication management/administration, assistance with dressing, meal reminders, escorts to activities, and safety checks. R10's Service plan lacked the service of compression wraps. On March 10, 2026, at 2:00 p.m., the surveyor and ULP-K observed R10 resting in her bed. R10 was wearing compression wraps on both lower extremities. ULP-K stated the compression wraps were put on in the morning and removed in the evening; however, R10 sometimes removed them on her own. R10's registered nurse (RN) Assessment dated February 23, 2026, indicated "Dressing Needs-Special, needs help with anti-embolism/compression stockings [wraps]-on and off', with additional notes, "Staff will assist resident with applying compression stockings [wraps] each morning and with removing them at night. Staff will wash stockings [wraps] in warm, soapy water and hang to dry overnight. Skin concerns will be reported to nursing immediately for assessment. R10's Service Recap Summary (used as documentation of services received) dated March 2026, included "Compression Stockings or Wraps" on in the morning and removed at bedtime. R10's Resident Note dated February 21, 2026, indicated "Resident returned from hospital today at 4pm [sic] via family vehicle. New orders for compression wraps daily to bilateral lower extremities and hold memantine 10 milligrams [mg]. Medication list updated and family aware as they transported resident home."	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SPRING VALLEY ESTATES	815 MEMORIAL DRIVE SPRING VALLEY, MN 55975

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01940	Continued From page 29 R10's record lacked an adequate prescriber's order for compression wraps. The licensee failed to update R10's Service Plan included the treatment of compression wraps. On March 11, 2026, at 11:41 a.m., CNS-B stated R10's service plan had not been updated to include her compression wraps. She further stated licensed assisted living director (LALD)-A managed the edits/updates to residents' Service Plans after the nurse updates the RN assessments. CNS-B stated, moving forward, the licensee is changing the process so that the changes in services (Service Plans) are completed by the CNS. The licensee's Contents of Service Plans dated August 2023, indicated all assisted living residents have an up-to-date service plan identifying services to be provided based on the assessment by the RN and/or other licensed health professional. Service plans are reviewed and revised as needed based upon on-going resident assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who	01960		

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SPRING VALLEY ESTATES	815 MEMORIAL DRIVE SPRING VALLEY, MN 55975

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01960	Continued From page 30 administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment services were documented for one of three residents (R1) with treatments. 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 began receiving services on December 27, 2022, with diagnoses including late onset Alzheimer's disease, anxiety disorder, and COPD (chronic obstructive pulmonary disease-a chronic lung disease). R1's Service Plan dated March 29, 2024, included the services of medication management/administration, bathing assistance, behavior management, grooming meal reminders, and safety checks. The Service Plan lacked assistance with dressing, toileting, oxygen saturation checks, and oxygen management.	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01960	Continued From page 31 On March 10, 2026, at 7:40 a.m., the surveyor observed unlicensed personnel (ULP)-J assist R1 out of bed, escort her to the bathroom, assist with toileting, complete an incontinence brief change and assist R1 to get dressed for the day. The surveyor also observed an oxygen concentrator and multiple portable oxygen cylinders in R1's room. ULP-J stated the staff checked R1's oxygen saturations three times daily and were to provide oxygen with low saturations. R1 only used oxygen as needed (PRN). R1's record included a signed order dated March 21, 2025, for oxygen that indicated "continuous oxygen at 4 liters/minute with exertion and 2 liters/minute while at rest." R1's record included a physician's visit note dated March 25, 2025, which indicated due to increased incidences of nose bleeds, and current stable oxygen levels, Oxygen changed from continuous to as needed (PRN) with facility staff to continue to monitor for decreased oxygen saturation levels. R1's medication record (MAR) dated March 2026, and Service Recap Summary dated March 2026, lacked documentation of R1's PRN Oxygen use or tubing changes. On March 11, 2026, at 11:33 a.m., clinical nurse supervisor (CNS)-B stated the licensee had not been documenting R1's use of oxygen since it was initiated in May 2025. The licensee's Documentation of Medication, Treatment and Therapies policy dated August 2023, indicated registered nurses (RNs), licensed practical nurses (LPNs), and ULPs will	01960		

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01960	Continued From page 32 appropriately document all medications, treatments, and therapy management services provided to residents including documentation of PRN medications and documentation of requesting and receiving prescription refills. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days.	01960		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of three residents (R10) receiving treatments. 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).	01970		

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01970	Continued From page 33 The findings include: R10 began receiving services on May 19, 2023, with diagnoses including dementia, depression, chronic kidney disease, and bradycardia (low heart rate). On March 10, 2026, at 2:00 p.m., the surveyor and unlicensed personnel (ULP)-K observed R10 resting in her bed. R10 was wearing her compression wraps on both lower extremities. ULP-K stated the compression wraps were put on in the morning and removed in the evening; however, R10 sometimes removed them on her own. R10's Service Plan dated June 6, 2023, included the services of medication management/administration, assistance with dressing, meal reminders, escorts to activities, and safety checks. R10's Service plan lacked the service of compression wraps. R10's registered nurse (RN) Assessment dated February 23, 2026, indicated "Dressing Needs-Special, needs help with anti-embolism/compression stockings [wraps]-on and off', with additional notes, "Staff will assist resident with applying compression stockings [wraps] each morning and with removing them at night. Staff will wash stockings [wraps] in warm, soapy water and hang to dry overnight. Skin concerns will be reported to nursing immediately for assessment. R10's Service Recap Summary (used as documentation of services received) dated March 2026, included "Compression Stockings or Wraps" on in the morning and removed at	01970		

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01970	Continued From page 34 bedtime. R10's Resident Note dated February 21, 2026, indicated "Resident returned from hospital today at 4pm [sic] via family vehicle. New orders for compression wraps daily to bilateral lower extremities and hold memantine 10 milligrams [mg]. Medication list updated and family aware as they transported resident home." R10's After Visit Summary (AVS-known as a hospital discharge summary) dated February 21, 2026, indicated she was hospitalized from February 19, 2026, through February 21, 2026, following a fall at the facility and noted bradycardia (low heart rate) and orthostatic hypotension (significant drop in blood pressure with changes in position). R10's Physical Therapy (PT) Inpatient Evaluation/Treatment note (written while a hospital patient) dated February 20, 2026, indicated "PT Plan Comments: Progress bed/out of bed mobility as able, continue to utilize abdominal binder/LE [lower extremity] wraps for OH (outside hospital) management. The licensee failed to ensure a current signed order for R10's compression wraps included a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy as required. On March 11, 2026, at 11:40 a.m., clinical nurse supervisor (CNS)-B stated she could not find an actual order for R10's compression wraps, but used the inpatient PT note (dated February 20, 2026,) as an order. She further stated the abdominal binder referenced in the PT note was	01970		

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01970	Continued From page 35 not being used at the time of R10's hospital discharge. CNS-B stated, "I know it's not a real order," and further stated the PT note did not include the required elements of a prescriber's order. A policy regarding Treatment Orders was requested but not received. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

Rochester District Office
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Spring Valley Estates
815 Memorial Drive
Spring Valley, MN 55975
Fillmore County
Parcel:

Phone: 507-346-1246
housing@springvalleyliving.org

License Info

License: HFID 30563
Dawn Hobkirk
Risk:
License:
Expires on:
CFPM: Deana Copeman
CFPM #: ; Exp:

Inspection Info

Report Number: F1045261036
Inspection Type: Full - Single
Date: 3/9/2026 Time: 11:22:31 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

THE ASSISTED LIVING AND MEMORY CARE RESIDENTS ARE SERVED BY THE ONSITE NURSING HOME FULLY SUPPLIED COMMERCIAL KITCHEN. A SMALL SERVING SPACE EXISTS IN BOTH THE ASSISTED LIVING AND MEMORY CARE LOCATIONS. BOTH EQUIPPED WITH RESIDENTIAL REFRIGERATION AND COMMERCIAL WAREWASHING UNITS.

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

I acknowledge receipt of the Rochester District Office inspection report number F1045261036 from 3/9/2026

Dawn Hobkirk
Licensed Assisted Living Director

Nicole Hunger,
Public Health Sanitarian 3
507-206-2741
nicole.hunger@state.mn.us

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL30563016-0	**Date:** 3/10/2026
Facility Name: SPRING VALLEY ESTATES	
Facility Address: 815 MEMORIAL DR, SPRING VALLEY, MN 55975	

☒ **TAG IDENTIFICATION: 0775**

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

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

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

   Comments: Assisted living resident room fire doors didn't close and latch, spring hinges or closing mechanism not attached to fire rated doors as required.

3. Single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests or exceed ten years from the date of manufacture. Smoke alarms shall be replaced with smoke alarms having the same type of power supply. [Minn. Stat. 144G.45 subd. 2; MSFC 1103.8.1]

   Comments: The hard-wired smoke alarms in multiple resident rooms were over 10 years past the manufacturer date. All smoke alarms shall be replaced with smoke alarms having the same type of power supply.

4. Controlled egress locking systems shall: unlock upon activation of either the automatic sprinkler system or automatic fire detection system, unlock upon loss of power controlling the lock, have the capability of being unlocked from the fire command center, a nursing station, or other approved location. Building occupants shall not be required to pass through more than one controlled egress locked door before entering an exit. The procedures for operation of the unlocking system shall be described as part of the fire safety and evacuation plan. All clinical staff shall have the keys, codes, or other means necessary to operate the locking device. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9.7]

   Comments: Facility controlled egress system was not equipped with a separate de-activate button or switch in the fire command center or other approved location to unlock the system.

5. In buildings that contain a fuel-burning appliance or fireplace, or attached private garage, carbon monoxide detection shall be installed in dwelling units within ten feet of bedrooms. Where a fuel burning appliance is located in a bedroom or its attached bathroom, carbon monoxide detection shall be installed within the bedroom. Carbon monoxide detection can be provided by carbon monoxide alarms installed in dwelling or sleeping units or a carbon monoxide detection system installed in the room or space that contains the fuel-burning appliance. [Minn. Stat. 144G.45 subd. 2; MSFC 915]

   Comments: The 24 memory care units didn't have carbon monoxide alarms in the resident rooms or alarms connected to the fire alarm panel at the source of fuel fire appliances.

☒ **TAG IDENTIFICATION: 0810**

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

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

   Comments: The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate).

2. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

   Comments: Surveyor requested all staff training on the FSEP from the licensed assisted living director (LALD)-A and environmental services director (EVSD)-N. LALD-A and EVSD-N stated they were using fire drills as training along with a web-based training that did not include the licensee's policy.