DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

June 23, 2023

Licensee
Valley Terrace Of Owatonna
1212 West Frontage Road
Owatonna, MN 55060

RE: Project Number(s) SL25302016

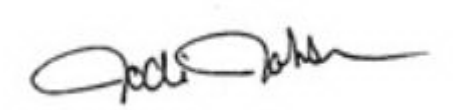
Dear Licensee:

On June 14, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the April 26, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-281-9796

JMD

Electronically Delivered

June 1, 2023

Licensee
Valley Terrace Of Owatonna
1212 West Frontage Road
Owatonna, MN 55060

RE: Project Number(s) SL25302016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 26, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH

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

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

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

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

Please address your cover letter for reconsideration requests to:

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

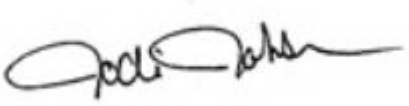
REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd.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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

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

If you have any questions, please contact me.

Sincerely,



Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-281-9796

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25302	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY TERRACE OF OWATONNA	1212 WEST FRONTAGE ROAD OWATONNA, MN 55060

(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: SL25302016 On April 24, 2023, through April 26, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 46 active residents; all receiving services under the Assisted Living license. Immediacy was removed as confirmed by onsite observation and document review on April 26, 2023, however, non-compliance remains at level 3, widespread (I).	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 470 SS=C	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

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0 470	Continued From page 1 (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the staffing plan was posted and visible to everyone. This had the potential to affect all of 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	0 470		

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0 470	Continued From page 2 or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During a facility tour on April 24, 2023, with licensed assisted living director (LALD)-A, LALD-A directed the surveyor to a posting that was behind a reception desk as the staff posting. The posting was not able to be read by residents and visitors. LALD-A stated it should be moved to a location that was visible to residents and visitors. The licensee's Staffing Management Plan last reviewed April 17, 2023, identified "The daily schedule will be posted monthly either on paper or electronic system as determined by facility." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was	0 480		

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0 480	Continued From page 3 prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated April 24, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to establish and maintain an infection control program that complies with accepted	0 510		

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0 510	Continued From page 4 health care, medical and nursing standards for infection control during medication administration by one of three unlicensed personnel (ULP-E) . This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 April 25, 2023, at 7:06 a.m. ULP-E, was observed administering medications to R8. During the administration of eye drops, the cap to the eye drops fell to the floor. ULP-E picked up the cap from the floor, placed the cap back on the eye drop bottle, and returned the eye drop bottle to the medication cart. On April 25, 2023, at 11:04 a.m. clinical nurse supervisor (CNS)-B stated if staff were to drop the cap to an eye drop bottle, it should either be disinfected with Sani-Wipes or the eye drops should be discarded and a new bottle ordered. Staff should not have picked it a cap up from the floor and placed it back on the bottle due to the risk for contamination. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment	0 550		

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0 550	Continued From page 5 All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post, in a conspicuous place, the required information related to the grievance procedure and contact information for the Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities. This had the potential to affect all the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 550		

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0 550	Continued From page 6 The findings include: During a facility tour on April 24, 2023, with licensed assisted living director (LALD)-A, a posting was observed on a bulletin board upstairs near the medication carts; however, it lacked e-mail contact information for the individuals who were responsible for handling resident grievances as required. LALD-A stated the posting was missing downstairs and she would need to repost it. The licensee's Complaint/Grievance Posting policy dated August 1, 2021, identified "[The licensee] will post, in a conspicuous place, information about our complaint/grievance procedure, and the name, telephone number, and email contact information for the individual(s) who are responsible for handling resident complaint/grievances." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center	0 640		

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0 640	Continued From page 7 to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: During a facility tour on April 24, 2023, with licensed assisted living director (LALD)-A, LALD-A stated the posting for information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and the 911 emergency number had been taken down and would need to be put back up in a common area. The licensee's Vulnerable Adult Maltreatment - Prevention & Reporting policy dated August 1,	0 640		

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0 640	Continued From page 8 2021, identified "[the licensee] will post information for reporting suspected crime and maltreatment. The facility will support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: a. Posting the 911 emergency number in common areas and near telephones provided by the assisted living facility. b. Posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff	0 680		

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0 680	Continued From page 9 orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure it completed a written emergency disaster plan with all required content as defined in Appendix Z. This had the potential to affect all current residents, staff, and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's emergency preparedness plan (EPP), provided to the surveyors, was a number of documents and policies contained in a three-ring binder. One document was a hazard vulnerability assessment. This assessment listed potential vulnerabilities and a listing of potential threats. Additionally, there was an internal emergency contact roster/list and numerous external emergency and service contacts.	0 680		

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0 680	Continued From page 10 The licensee's plan failed to conduct exercises to test the EPP at least twice per year, including unannounced staff drills using the EPP. On April 26, 2023, at approximately 2:00 p.m. the licensed assisted living director (LALD)-A confirmed they had not completed any full-scale community drills. The licensee's Disaster Planning and Emergency Preparedness policy dated June 2021, indicated all Appendix Z requirements are to be followed. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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 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. This deficient condition had the ability	0 800		

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	25302	A. BUILDING: _____ B. WING _____	04/26/2023

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VALLEY TERRACE OF OWATONNA	1212 WEST FRONTAGE ROAD OWATONNA, MN 55060

(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
0 800	Continued From page 11 to affect a limited number of staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 April 26, 2023, between 9:30 a.m. and 12:00 p.m. with Licensed Assisted Living Director (LALD)-A, it was observed that there was water damage to many ceiling tiles throughout the facility. During interview, LALD-A stated that there were issues with the roof of the structure and contractors had begun work on a very substantial roof repair project. This issue was known to them when the building ownership changed (in 2022) and work began immediately to address the situation. The process is on track but many of the tiles had not been replaced yet. This deficient condition was visually verified by LALD-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:	0 810		

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0 810	Continued From page 12 (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 provide required employee training on fire safety and evacuation, failed to train residents capable of assisting in their own evacuations, and failed to complete required employee evacuation drills. This had the potential to affect all staff, residents, and visitors.	0 810		

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0 810	Continued From page 13 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: An interview and record review were conducted on April 26, 2023, between 12:30 p.m. and 1:00 p.m. with the Licensed Assisted Living Director (LALD)-A on the fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. Record review indicated that employees did not receive training twice per year after initial hire. During interview, LALD-A stated that the licensee provided annual training to employees. The company's policy indicated that employee training was to be provided at hire and twice per year thereafter, but the provided documents showed it was completed annually. This deficiency was verified by LALD-A during the interview. Record review also indicated that evacuation drills for employees had not been performed twice per year per shift and held every other month as required. During interview, LALD-A stated that evacuation drills had not been performed adequately for the employees and provided documentation for one (1) evacuation drill. This deficiency was verified by LALD-A during the interview.	0 810		

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0 810	Continued From page 14 Record review also indicated that residents who can assist in their own evacuation had not been trained on the proper actions at least once per year. During interview, LALD-A stated that residents were provided information on fire and safety evacuation upon acceptance into the facility, but no program or documentation was provided after initial entry. This deficiency was verified by LALD-A during the interview. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for four of four residents (R3, R4, R5 and R7). This practice resulted in a level one violation (a violation that has no potential to cause more than	0 910		

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0 910	Continued From page 15 a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R3, R4, R5, and R7's Assisted Living Residency Agreements included a license number, but failed to have the health facility identification (HFID) number on the contract as required. R3 R3 began receiving assisted living services from the licensee on July 1, 2022. R3's Assisted Living Contract dated July 1, 2022, included a license number, but failed to have the HFID number on the contract as required. R4 R4 began receiving assisted living services from the licensee on July 1, 2022. R4's Assisted Living Contract dated July 1, 2022, included a license number, but failed to have the HFID number on the contract as required. R5 R5 began receiving assisted living services from the licensee on January 27, 2023. R5's Assisted Living Contract dated July 1, 2022, included a license number, but failed to have the HFID number on the contract as required. R7	0 910		

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0 910	Continued From page 16 R7 began receiving assisted living services from the licensee on July 1, 2022. R7's Assisted Living Contract dated July 1, 2022, included a license number, but failed to have the HFID number on the contract as required. On April 4, 2023, at 2:34 p.m. licensed assisted living director (LALD)-A stated that all contracts were the same and failed to include the HFID number as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident for four of four residents (R3, R4, R5 and R7). This practice resulted in a level one violation (a	0 970		

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0 970	Continued From page 17 violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R3 began receiving assisted living services from the licensee on July 1, 2022. R4 began receiving assisted living services from the licensee on July 1, 2022. R5 began receiving assisted living services from the licensee on January 27, 2023. R7 began receiving assisted living services from the licensee on July 1, 2022. R3, R4, R5 and R7's assisted living contracts contained the following information: - "2. INDEMNIFICATION Resident will indemnify and hold harmless Provider, its employees and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by Resident of the rented premises or any other part of Provider's property, or caused wholly or in part by an act or omission of Resident or Resident's guests or agents." - "4. LIABILITY Provider is not liable to Resident or Resident's guests for any injury, death or property damage occurring in the Apartment Unit or on Provider's premises unless .such injury, death or property	0 970		

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0 970	Continued From page 18 damage occurs as the result of an equipment malfunction or hazardous conditions within the building not caused by Resident or Resident's guests. Provider is also not liable for any injury, death or damage occurring as the result of Resident's receipt of health-related, supportive or other services from third party providers. Provider may be liable to Resident for its own negligent acts or those of its employees or agents. Unless caused by one of the aforementioned excepted reasons, Resident agrees to hold Provider harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the Apartment Unit or on Provider's premises." On April 4, 2023, at 2:34 p.m. licensed assisted living director (LALD)-A stated all contracts would be the same and would include the information noted above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01060 SS=E	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;	01060		

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01060	Continued From page 19 (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 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 the required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for	01060		

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01060	Continued From page 20 three of three residents (R5, R1, R2). 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R5 started receiving services on January 27, 2023, for diabetes, hypertension (high blood pressure), and chronic back pain. R5's service plan last updated on March 8, 2023, indicated R5 received assistance with activities of daily living (ADL), medication administration, housekeeping, and laundry. R5 was admitted to the hospital from February 3, 2023, returning to the facility from transitional care on March 8, 2023. R5's record lacked a written notice including: -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 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	01060		

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01060	Continued From page 21 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. In addition, R5's record lacked notification to the Office of Ombudsman for Long-Term Care that the resident had been relocated and had not returned to the facility within four days. R1 R1 began receiving assisted living services from the licensee on July 1, 2022. R1's resident notes dated April 13, 2023, identified R1 had been transported to the emergency room. As of the time of the survey, R1 remained in the hospital. R1's record failed to identify the resident, the resident's representative, and the resident's case manager had been provided, as soon as practicable, a written notice that contained: -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; and -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.	01060		

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01060	Continued From page 22 In addition, R1's record lacked notification to the Office of Ombudsman for Long-Term Care that the resident had been relocated and had not returned to the facility within four days. R2 R2 began receiving assisted living services from the licensee on July 1, 2022. R2's resident notes dated February 23, 2023, identified R2 had been transported to the emergency room. R2 was later discharged to a skilled care facility on March 20, 2023. R2's record failed to identify the resident, the resident's representative, and the resident's case manager had been provided, as soon as practicable, a written notice that contained: -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; and -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. In addition, R2's record lacked notification to the Office of Ombudsman for Long-Term Care that the resident had been relocated and had not returned to the facility within four days.	01060		

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01060	Continued From page 23 On April 26, 2023, at 12:40 p.m. the clinical nurse supervisor (CNS)-B confirmed R5's file lacked evidence of notification of R5's extended hospital stay. CNS-B stated they were not aware of the process at that time and so none of the files would have one. The licensee's emergency relocation policy dated August 1, 2021, indicated in the event of an emergency relocation, [the licensee] will provide a written notice that contains, at a minimum: a. The reason for the relocation b. The name and contact information for the location to which the resident has been relocated and any new service provider. c. Contact information for the Office of Ombudsman for Long-term Care d. 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 e. A statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to 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, 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.	01060		

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01060	Continued From page 24 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a reassessment not to exceed 90 days for two of three residents (R4, R7). This practice resulted in a level two violation (a	01620		

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	25302	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY TERRACE OF OWATONNA	1212 WEST FRONTAGE ROAD OWATONNA, MN 55060

(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
01620	Continued From page 25 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4 R4 began receiving assisted living services from the licensee on July 1, 2022. R4's record included comprehensive assessments completed by the RN dated May 13, 2022, and February 13, 2023. The record lacked evidence of any comprehensive assessments completed between those dates. There was 286 days between the assessments. An April 26, 2023, at 11:31 a.m. CNS-B stated she was aware the assessments had not been completed timely. R7 R7 started receiving services from the licensee on September 20, 2019, with diagnoses including congestive heart failure (COPD), osteoarthritis, and depression. R7's record indicated the assessments by the RN had completion dates as follows: - June 9, 2022; and - January 3, 2023 (208 days from previous assessment) On April 26, 2023, at 11:00 a.m. the clinical nurse supervisor (CNS)-B confirmed R7's file contained	01620		

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01620	Continued From page 26 assessments that exceeded the 90-day requirement. CNS-B stated she was aware of the requirement and going forward they will follow the regulation. The licensee's Assessments, Reviews and Monitoring Policy dated August 2021, indicated assessments must be conducted no more than 14 calendar days after initiation of services. Ongoing Resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced	01760		

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01760	Continued From page 27 by: Based on observation, interview, and record review, the licensee failed to follow prescriber orders for one of 18 residents (R3) reviewed with medication administration. 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 April 25, 2023, at 7:20 a.m. unlicensed personnel (ULP)-D was observed administering medications to R3. R3's diagnoses included major depressive disorder, asthma, edema, hypertension, and glaucoma. R3's service plan dated April 10, 2023, identified R3 received medication administration services. R3's physician orders signed by a medical provider on April 10, 2023, identified benzonatate (medication for cough) 100 mg (milligrams) take 1 capsule three times daily as needed for cough, was to be discontinued. R3's medication administration record dated April 1, 2023, through April 25, 2023, identified benzonatate had been administered after the discontinuation order on the following dates: - April 11, 2023, three doses;	01760		

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01760	Continued From page 28 - April 12, 2023, two doses; - April 13, 2023, one dose; - April 15, 2023, one dose; - April 16, 2023, one dose; - April 17, 2023, one dose; and - April 20, 2023, one dose. On April 25, 2023, at 10:45 a.m. licensed practical nurse (LPN)-H stated the facility had received a large stack of orders from a provider at the same time. The facility was trying to clean up orders and discontinue as needed medications that were no longer in use. Due to the large volume of orders received all at once, they just did them as they got to them. On April 25, 2023, at 11:04 a.m. clinical nurse supervisor (CNS)-B stated physician orders should be processed within 24 hours of receiving the orders. The licensee's Medication and Treatment Orders - Implementing policy, dated August 1, 2021, identified "Medication and treatment/therapy orders received by [the licensee] must be implemented within 24 hours of receipt." "Upon receipt of a medication and/or treatment order, whether new or change of an order from an authorized prescriber, a licensed nurse must take action to implement the order within 24 hours." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
02240 SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification	02240		

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02240	Continued From page 29 (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. If you would like to request advocacy services, you may contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, email address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, email, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the	02240		

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02240	Continued From page 30 assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents was provided to all residents residing at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: Admission information including Minnesota Bill of Rights for Assisted Living Residents dated May 16, 2021, was provided.. On April 4, 2023, at 2:34 p.m. licensed assisted living director (LALD)-A stated she was unaware there was a revised Minnesota Bill of Rights for Assisted Living Residents in August 2022. All residents would have received the May 16, 2021, version. The licensee's Bill of Rights policy dated August 1, 2021, identified "[The licensee] will provide each resident with the Assisted Living Care Bill of Rights." "1. [The licensee] will provide the resident or the resident's representative a written copy of the	02240		

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02240	Continued From page 31 Assisted Living Bill of Rights {BOR) before the date that services are first initiation of services to the resident. 2. [The licensee] will make all reasonable efforts to provide the BOR to the resident or the resident's representative in a language the resident or resident's representative can understand. 3. [The licensee] must obtain written acknowledgment of the resident's receipt of the BOR or shall document why an acknowledgment cannot be obtained. The acknowledgment may be obtained from the resident or the resident's representative. 4. Acknowledgment of BOR receipt will be retained in the resident's record." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		
02310 SS=I	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: 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 two of two residents (R3, R6) with side rails. This resulted in an immediate order issued on April 26, 2023, at	02310		

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02310	Continued From page 32 approximately 10:10 a.m. 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: R3 R3's was admitted to the facility on November 13, 2020. R3's diagnoses included diabetes, major depressive disorder, hemiplegia, gait abnormality, and adult failure to thrive. R3's service plan dated April 4, 2023, identified R3's services included assistance with bathing, bed mobility, dressing, management of behaviors, and medication administration. R3's Bed Safety Assessment dated April 4, 2023, identified R3 had hospital bed side rails. It indicated the measurements on the zones were within the Food and Drug Administration (FDA) guidelines for zone two, zone three, and zone four. The assessment failed to identify zone one and failed to identify any measurements of the zones one through four. On April 26, 2023, at 9:19 a.m. the surveyor observed R3 had bilateral upper half side rails on a hospital bed. R3 stated she preferred the side rail on the right side of the bed to be in the down position, but she used the side rail on the left side of the bed to assist in positioning in bed.	02310		

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02310	Continued From page 33 On April 26, 2023, at 10:10 a.m. clinical nurse supervisor (CNS)-B stated R3's assessment should have included information on zone one and if it was within FDA guidelines. In addition, measurements of zones one through four should have been documented. CNS-B further stated since it was not documented on the assessment, the measurements were probably not completed. R6 R6 began receiving services on May 8, 2010, with diagnoses including traumatic brain injury (TBI), and stroke. R6's service plan dated April 10, 2023, indicated R6 received assistance with housekeeping, laundry, and medication management. On April 24, 2023, at 9:30 a.m. the surveyor observed a U-shaped consumer side rail attached securely to R6's queen size bed on the right side at the head of the bed. R6's bed rail assessment dated April 10, 2023, indicated no assistive devices were needed. On April 26, 2023, at 10:10 a.m. clinical nurse supervisor (CNS)-B stated she went into R6's room and verified he had a side rail that had been recalled. She stated "we did not know he has had a side rail, and he states he has had it for 20 years." On April 26, 2023, at 11:31 a.m. CNS-B further stated the side rail assessments were not accurate and measurements had not been completed on hospital bed rails. CNS-B was unsure how many additional side rails were in the	02310		

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02310	Continued From page 34	02310		

facility, and they would need to complete an audit and reassess all residents.

The licensee's Side rails policy dated August 1, 2021, indicated the licensee will assess the use, educate the resident and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verifying that the side rail in use is not a safe design and utilized consistent with the manufacturer's directions.

The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (space between the rails), zone 2 (space under the rail, between the rail supports) zone 3 (space between the rail and mattress), should be less than 4 and 3/4 inches. Zone 4 (space under the rail at the ends of the rail, between the rail and mattress) should be less than 2 and 3/8 inches.

The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe".

The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess

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02310	Continued From page 35 the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	02310		

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02310	Continued From page 36 Immediacy was removed as confirmed by onsite observation and document review on April 26, 2023, however, non-compliance remains at level 3, widespread (I). TIME PERIOD FOR CORRECTION: Two (2) days	02310		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors of the licensee. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	03090		

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03090	Continued From page 37 On April 24, 2023, at approximately 10:30 a.m. upon arriving at the establishment, an observation outside the front entrance, or just inside the front entrance, lacked the required posting for electronic monitoring devices. During a facility tour on April 24, 2023, with licensed assisted living director (LALD)-A, LALD-A stated the electronic monitoring sign should have been posted by the entrance and she was unsure why it was not there. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *04/24/23*
Time: 12:46:51
Report: 8044231132

Food and Beverage Establishment Inspection Report

Location:
Valley Terrace of Owatonna
1212 West Frontage Road
Owatonna, MN55060
Steele County, 74

Establishment Info:
ID #: 0037473
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5074463522
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.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ** Priority 1 **

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

Turkey sandwiches and cole slaw stored on ice rather than mechanical refrigeration.

Foods moved to walk in cooler upon request.

Comply By: 04/24/23

3-500A Microbial Control: cooling

3-501.15A ** Priority 2 **

MN Rule 4626.0390A Cool food by: 1) placing the food in shallow pans; 2) separating the food into smaller portions 3) using rapid cooling equipment; 4) stirring the food in a container placed in an ice water bath; 5) using containers that facilitate heat transfer; 6) adding ice as an ingredient; or other effective methods.

Potato casserole, pulled pork, chili cooled in deep plastic containers.

Comply By: 04/24/23

3-500A Microbial Control: cooling

3-501.15B ** Priority 2 **

MN Rule 4626.0390B Loosely cover containers of cooling food and arrange in cold holding equipment in a manner to maximize heat transfer through the container walls.

Spaghetti sauce with meat cooling in covered container.

Cover removed while on site.
Comply By: 04/24/23

4-300 Equipment Numbers and Capacities
4-302.14 ** Priority 2 **
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

Unable to locate chlorine test kit.
Comply By: 05/01/23

3-300C Protection from Contamination: equipment/utensils, consumers
3-304.14B
MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.

Quaternary ammonium measured at 100 ppm, rather than 200 ppm in wiping cloth buckets.
Comply By: 04/24/23

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.

Ham thawing in stagnant water.
Comply By: 04/24/23

4-900 Protecting Clean Items
4-903.11A
MN Rule 4626.0955A Store all clean equipment, utensils, linens, single-service and single-use articles in a clean dry location where not exposed to splash, dust, or other contamination and at least six inches above the floor.

Bottom shelf of white storage shelf less than six inches off ground.
Comply By: 04/24/23

6-100 Physical Facility Construction Materials

6-101.11A1

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

Acoustical tiles installed in kitchen. These are not easy to clean.

Missing ceiling tiles in dry storage room.

Comply By: 05/24/23

6-200 Physical Facility Design and Construction

6-201.13A

MN Rule 4626.1345A Properly cove and seal the wall/floor junctures to no larger than 1/32 inch (1 millimeter).

Coved base missing from floor/wall juncture beneath prep sink.

Comply By: 04/24/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

Peeling paint from block wall in men's restroom.

Stained ceiling tiles in dry storage rooms and kitchen.

Comply By: 07/24/23

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.19

MN Rule 4626.1555 Keep the toilet room doors closed except during cleaning and maintenance operations.

Women's restroom door propped open.

Comply By: 04/24/23

Surface and Equipment Sanitizers

Chlorine: = 50 ppm at Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Quaternary Ammonia: = 100 ppm at Degrees Fahrenheit
Location: Bucket
Violation Issued: Yes

Quaternary Ammonia: = 100 ppm at Degrees Fahrenheit
Location: Bucket
Violation Issued: Yes

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

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 172.0 Degrees Fahrenheit - Location: Lasagna
Violation Issued: No

Process/Item: Hot Holding
Temperature: 158.6 Degrees Fahrenheit - Location: Steak kabobs
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37.0 Degrees Fahrenheit - Location: WIC
Violation Issued: No

Process/Item: Cooling
Temperature: 50.1 Degrees Fahrenheit - Location: Meat sauce at 1:01 pm
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38.8 Degrees Fahrenheit - Location: Pulled pork in WIC
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38.3 Degrees Fahrenheit - Location: Egg bake
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	3	7

HRD Inspection conducted with Nurse Evaluator Tracey Fearon and Stacy Haag.

Inspection report reviewed on site with Alissa.

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8044231132 of 04/24/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Signed:_____ Signed:_____

Inspector signed for Alissa

Michael DeMars, RS
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