



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 22, 2025

Licensee
Twin Valley Assisted Living
208 Oppegard Avenue Northwest
Twin Valley, MN 56584

RE: Project Number(s) SL35519016

Dear Licensee:

On June 11, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on March 19, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

JMD



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 16, 2025

Licensee

Twin Valley Assisted Living
208 Oppegard Avenue Northwest
Twin Valley, MN 56584

RE: Project Number(s) SL35519016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 19, 2025, 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 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.

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

0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$500.00

1760 - 144g.71 Subd. 8 - Documentation Of Administration Of Medication - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,500.00.** 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.

INFORMAL CONFERENCE

In accordance with Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Twin Valley Assisted Living. Please contact Jessie Chenze at 218-332-5175 on or before Monday, April 21, 2025 to schedule the conference call.

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,

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

Jessie Chenze, Supervisor

State Evaluation Team

Email: jessie.chenze@state.mn.us

Telephone: 218-332-5175 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER TWIN VALLEY ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 208 OPPEGARD AVENUE NW TWIN VALLEY, MN 56584		
(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 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: SL35519016-0 On March 17, 2025, through March 19, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 15 residents; 15 receiving services under the Assisted Living Facility with Dementia Care license.	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.		
0 100 SS=F	144G.10 Subdivision 1 License required (a)(1)Beginning August 1, 2021, no assisted living	0 100			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 100	Continued From page 1 facility may operate in Minnesota unless it is licensed under this chapter. (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b)The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided. (e) Upon approving an application for an assisted living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care.	0 100			

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0 100	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to demonstrate legal responsibility for the control and operation of the facility when the licensee allowed use of the facility space to operate a county public health office. 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 the entrance conference on March 17, 2025, at 10:14 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. On March 17, 2025, at 10:00 a.m., the surveyor arrived at the facility. Adjacent to the main entrance door of the assisted living facility was another door labeled 5A with signage, which indicated a county public health office was located in the same building with the same address as the assisted living facility. During the facility tour on March 17, 2025, from 10:44 a.m., through 11:12 a.m., with clinical nurse	0 100			

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0 100	Continued From page 3 supervisor (CNS)-B, the surveyor did not observe any entrance to the county public health office from inside of the assisted living building. On March 19, 2025, from 10:00 a.m., through 12:00 p.m., the Minnesota Department of Health (MDH) engineer surveyor toured the facility with LALD-A, regional director of maintenance (RDM)-I, and director of maintenance (DM)-D. The MDH engineer surveyor requested building construction drawings, in order to verify the fire-resistance rating of the occupancy separation wall common with the county public health office within the same building. On March 19, 2025, at 12:20 p.m., the MDH engineer surveyor reviewed the available building construction drawings with LALD-A, RDM-I, and DM-D, and was not able to verify the fire-resistant rating of the occupancy separation wall common with the county public health office in the same building as the licensed assisted living. On March 19, 2025, at 12:30 p.m., the MDH engineer surveyor observed construction of the occupancy separation wall and was not able to verify the fire-resistant rating of the wall common with the county public health office in the same building as the licensed assisted living. The attached county public health office occupancy was surveyed the same as the licensed assisted living portion of the building. At the time of the facility tour, the MDH engineer surveyor did not observe any violations in the county public health office. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 100			

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0 100	Continued From page 4 days	0 100			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of	0 480			

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0 480	Continued From page 5 a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 18, 2025, for the specific	0 480			

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0 480	Continued From page 6	0 480			
	Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.				
	TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.				
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services	0 485			
	All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract.				
	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 require any resident to include and pay for meals as a part of their assisted living contract. This had the potential to affect all residents.				
	This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not				

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0 485	Continued From page 7 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: During the entrance conference on March 17, 2025, at 10:14 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. On March 17, 2025, at 10:18 a.m., LALD-A stated the licensee provided an assisted living contract with a meal addendum for residents to elect to receive the meal plan (three meals per day) or opt out of the meal plan. On page seven of the undated Assisted Living Contract, Section 1: Housing Related Services Included in the Monthly Rent indicated availability of three (3) nutritious meals per day, with options for a specialized diet. On page 10 of the licensee's Resident Handbook, Section Meals (including guest meals) and Menus indicated entering into a Meal/Food Plan [sic] with the community (licensee) is entirely optional and is not required to become or remain a resident. To sign up, please complete the Meal/Food Plan Addendum [sic] found in your (resident) Assisted Living [sic] contract. The licensee's undated Meal/Food Plan Addendum indicated the resident could be provided three meals per day with the food plan or could select no meal plan through the licensee.	0 485			

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0 485	Continued From page 8 Resident assisted living contracts with meal addendums lacked an option for residents to opt out of payment for one or two meals residents would not want. On March 17, 2025, at 2:20 p.m., LALD-A stated the licensee offered residents a meal plan that included three meals per day or for the resident to opt out of all meals. LALD-A further stated the licensee was not aware the licensee needed to offer residents the option to opt out of one or two meals in addition to the option of having no meals provided. The Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQs) website, last updated December 13, 2024, indicated the provider cannot have a blanket "one size fits all" meal charge. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485			
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.	0 510			

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0 510	Continued From page 9 (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure services were provided according to accepted health care, medical, or nursing standards in regard to infection control during resident cares for one of two employees (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: During the entrance conference on March 17, 2025, at 10:17 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided assistance with ADLs (activities of daily living) to residents at the facility. ULP-E's on-line employee transcript indicated ULP-E completed Infection Control Techniques training on May 16, 2024. On March 18, 2025, at 7:17 a.m., ULP-E completed hand hygiene, ULP-E put on a pair of gloves, and cleansed R4's peri area with wet wipes. With the same gloved hands, ULP-E put on R4's underwear, pants, and slippers. ULP-E proceeded to use the sit to stand lift and transferred R4 into R4's wheelchair with the same	0 510			

Minnesota Department of Health

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0 510	Continued From page 10 gloved hands. ULP-E cleaned R4's glasses, removed ULP-E's gloves, made R4's bed, put R4's dirty gloves in the laundry basket, and ULP-E washed ULP-E's hands. On March 18, 2025, at 10:16 a.m., ULP-E stated ULP-E should have removed gloves, completed hand hygiene, and put on a new pair of gloves after ULP-E completed peri care for R4. ULP-E further stated ULP-E was nervous with the surveyor present in R4's room. On March 18, 2025, at 10:20 a.m., licensed assisted living director (LALD)-X stated ULP-E was trained on infection control, glove use, and hand washing requirements upon hire with the licensee. On March 18, 2025, at 10:21 a.m., CNS-B stated ULPs were trained to change gloves and complete hand hygiene after completion of resident peri care. CNS-B further stated ULPs were trained to change gloves and complete hand hygiene anytime ULPs were exposed to blood or bodily fluids. The licensee's Gloves policy dated August 1, 2021, indicated gloves are to worn [sic] whenever there may be direct contact between any employee and contaminated objects. The policy further indicated if gloves were contaminated to remove them and rewash hands. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			

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0 580	Continued From page 11	0 580			
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level 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: During the entrance conference on March 17, 2025, at 10:33 a.m., licensed assisted living director (LALD)-A stated the licensee had a	0 580			

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0 580	Continued From page 12 quality management program in place and the licensee's staff had met quarterly to discuss the quality management plan. The licensee's Quality Improvement Meeting Minutes dated December 20, 2023, indicated the next quality improvement meeting was scheduled for January 23, 2024, and the meetings would be scheduled quarterly thereafter. On March 17, 2025, at 2:17 p.m., LALD-A stated LALD-A was unable to locate any quality management documentation after December 20, 2023, and the previous LALD must not have completed the required documentation for the licensee. The licensee's Quality Improvement Project dated August 1, 2021, indicated the licensee will have at least one documented Quality Improvement Project [sic] in place at all times and retain records of such projects for at least two years. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580			
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be	0 630			

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0 630	Continued From page 13 taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of two residents (R7). 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: During the entrance conference on March 17, 2025, at 10:14 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. R7's diagnoses included vascular dementia. R7's service plan dated December 20, 2024, indicated R7 received medication administration, safety checks, and assistance with grooming, dressing, bathing, and toileting. On March 18, 2025, at 8:15 a.m., the surveyor observed unlicensed personnel (ULP)-F provide	0 630			

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0 630	Continued From page 14 scheduled morning medication administration to R7. R7's resident record contained an IAPP dated February 27, 2025, which addressed R7's risk of being abused by others and R7's risk of abusing other vulnerable adults. R7's resident record lacked resident's risk for self-abuse. On March 19, 2025, at 2:53 p.m., clinical nurse supervisor (CNS)-B stated R7's assessment lacked R7's risk for self-abuse and CNS-B must have missed filling out that portion of R7's IAPP. CNS-B further stated all resident's IAPPs had a section to address resident's risk for self-abuse. The licensee's Vulnerable Adults-Maltreatment, Communication, Prevention, and Reporting Plan policy dated August 1, 2021, indicated each resident shall have an IAPP that is reviewed annually or with a change in condition. The policy did not address specific areas assessed in a resident's IAPP. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control	0 660			

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0 660	Continued From page 15 and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and Minnesota Department of Health (MDH), including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of two employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on March 17, 2025, at 10:14 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living	0 660			

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0 660	Continued From page 16 requirements. The licensee's Facility TB Risk Assessment Worksheet for Health Care Settings Licensed by MDH was completed on June 2024 [sic], and the facility was determined to be a low risk level. ULP-C was hired on December 26, 2024, to provide direct care services to residents at the assisted living facility. On March 18, 2025, from 6:34 a.m., through 7:04 a.m., the surveyor observed ULP-C interact with residents at the facility. ULP-C's employee record contained a negative Employee TB Screening Initial [sic] dated December 26, 2024. ULP-C's employee record lacked evidence of completion of a two-step TST or other evidence of TB screening such as a blood test. On March 18, 2025, at 9:28 a.m., LALD-A stated ULP-C's record did not contain a two-step mantoux as required. LALD-A further stated all employees were supposed to complete a two-step mantoux upon hire with the licensee. The licensee's TB Plan, Staff Screening, Resident Assessment policy dated August 1, 2021, indicated new staff shall have a two-step Mantoux [sic] conducted with results documented on the Baseline TB Screening Tool for HCW's (health care workers). The policy further indicated documented blood tests shall be an acceptable substitute for a two-step Mantoux [sic]. The MDH TB Screening and Education Requirements for Assisted Living Facilities and	0 660			

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0 660	Continued From page 17 Home Care Providers dated February 3, 2022, indicated baseline TB screening is required at the time of hire for all health care personnel in Minnesota. Baseline TB screening includes assessing for current symptoms of active TB disease; assessing TB history; and testing for the presence of infection with Mycobacterium TB by administering either a two-step TB skin test or a single TB blood test. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 680 SS=C	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are	0 680			

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0 680	Continued From page 18 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 the missing resident policy was reviewed quarterly. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 17, 2025, at 10:14 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. The licensee's undated Emergency Preparedness Plan (EPP) included a Missing Resident/Elopement of Resident policy. The licensee's EPP provided did not include a quarterly review of the Missing Resident/Elopement of Resident policy. On March 18, 2025, at 1:15 p.m., LALD-A stated the missing resident policy was supposed to be reviewed on a quarterly basis, however, LALD-A was unable to find documentation of the missing	0 680			

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0 680	Continued From page 19 resident policy being reviewed quarterly by the previous LALD. The licensee's Missing Resident/Elopement of Resident policy dated August 1, 2021, indicated the licensee will review this (Missing Resident/Elopement of Resident) policy at least quarterly. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110, Subp. 4, effective October 2022, the assisted living director and clinical nurse supervisor must review the missing resident plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
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 and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	0 775			

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0 775	Continued From page 20 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). Findings include: On a facility tour on March 19, 2025, from 10:00 a.m. to 12:00 p.m., with licensed assisted living director (LALD)-A, regional director of maintenance (RDM)-I, director of maintenance (DM)-D, the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: EXIT DOOR LOCKING ARRANGEMENTS There was a delayed egress locking system installed on all exit doors leading to the exterior exit path. The delayed egress door locking system was not provided with a device capable of deactivating the delayed egress door hardware to the unlocked position from the nurse station or other approved location in order for occupants to exit in the event of an emergency. The delayed egress locking system is required to be provided with a switch or device located at the nurse station or other approved location to deactivate the delayed egress locked exit doors in order for building occupants to exit in the event of an emergency. During an interview at 9:45 a.m., LALD-A, and RMD-I, stated the procedures required to operate and unlock the delayed egress door locking system were not included in the fire safety and	0 775			

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0 775	Continued From page 21 evacuation plan. The procedures required to operate and unlock the delayed egress locking system in order for occupants to exit in the event of an emergency are required to be included in the fire safety and evacuation plan employee procedures. These procedures are required in accordance with MSFC in Minnesota Rules Chapter 7511. FIRE SPRINKLER SYSTEM MAINTENANCE During the tour the required annual maintenance and test report for the fire sprinkler system was requested and LALD-A, stated they would provide the document by email. On March 26, 2025, at 4:03 p.m., RDM-I, provided the fire sprinkler test and inspection reports dated May 7, 2025 by email. During document review on March 27, 2025, at 8:00 a.m., the required five year maintenance of all three systems was last completed in 2017 as indicated in the provided test report. The fire sprinkler system shall be maintained in the required sequence in accordance with MSFC in Minnesota Rules Chapter 7511 and National Fire Protection Association 25. FIRE-RESISTANT RATED DOORS The door closer arm was removed from the fire-resistant rated laundry room door near the serving kitchen and the door would not close and latch automatically. Fire-resistant rated doors are required to be maintained as designed and installed at the time	0 775			

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0 775	Continued From page 22 of construction approval. The fire-resistant rated door is required to automatically close and latch to prevent the spread of smoke and fire to the corridor in the event of a fire in the laundry room. EXIT SIGNS The exit signs were not provided with a test button to verify that backup power is provided to illuminate the exit signs at all times the building is occupied. During the tour RMD-I, and DM-D, stated they were not sure how the exit signs were provided with emergency backup power to illuminate the signs in the event of a power loss. Exit signs are required to be internally or externally illuminated at all times the building is occupied to lead occupants to an exit in the event of a fire or similar emergency. During the facility tour LALD-A, RMD-I, and DM-D, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775			
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.	0 800			

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0 800	Continued From page 23 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on March 19, 2025, from 10:00 a.m. to 12:00 p.m., with licensed assisted living director (LALD)-A, regional director of maintenance (RDM)-I, director of maintenance (DM)-D, the surveyor made the following observations of facility disrepair: HANDRAILS There was a broken handrail with sharp ends in the corridor near resident sleeping unit 719. Handrails are required to be maintained free of sharp ends that cause injury and be returned and fastened to the wall.	0 800			

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0 800	Continued From page 24 WATER DISTRIBUTION SYSTEM There was water on the floor caused by a leak under the walk-in tub in the shower room near the serving kitchen. There was open domestic water lines not connected to a plumbing fixture in the oxygen storage room without a cap or plug to prevent water flow into the room in the event the inline shut off valve was inadvertently turned on. It was explained to LALD-A, RMD-I, and DM-D, that open water lines are required to be provided with a plug or cap to prevent inadvertent water flow into the occupied space in the event the inline shut off valve is turned on. During the tour, LALD-A, RMD-I, and DM-D, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (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	0 810			

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0 810	Continued From page 25 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 develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 810			

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0 810	Continued From page 26 The findings include: On March 19, 2025, 9:00 a.m., licensed assisted living director (LALD)-A, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee provided FSEP undated, failed to include the following: The available FSEP did not identify specific fire protection actions for residents as evident by not providing procedures for residents to take in this specific facility in the event of a fire or similar emergency in writing in the FSEP. During an interview on March 19, 2025, at 9:25 a.m., LALD-A, stated resident actions/ procedures required during a fire or similar emergency were not included in writing in the FSEP. TRAINING Record review of the available documentation indicated the licensee failed to provide evacuation training to residents at least once per year as evident by not providing documentation the required FSEP training for residents was provided. During an interview on March 19, 2025, at 9:35 a.m., LALD-A, stated documentation was not available indicating FSEP training was provided to residents as required. DRILLS	0 810			

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0 810	Continued From page 27 Record review of the available documentation indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift as evident by not providing documentation the required number of evacuation drills were completed during the night shift. During an interview on March 19, 2025, at 9:45 a.m., LALD-A, stated documentation was not available indicating evacuation drills were completed twice annually during the night shift. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement	01060			

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01060	Continued From page 28 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 written notice with required content to the resident, legal representative, and designated representative, and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for one of one resident (R5). 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	01060			

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01060	Continued From page 29 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 17, 2025, at 10:14 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. The licensee's Current Resident Roster- Assisted Living (144G) dated March 17, 2025, indicated R5 was admitted to the facility on September 20, 2023, R5 had a hospitalization, and R5's services were on hold. R5's diagnoses included hypertension (HTN-high blood pressure), diabetes, and right hip fracture. R5's service plan dated August 1, 2024, indicated R5 received medication administration, behavior management, and assistance with bathing, grooming, dressing, and light housekeeping. R5's Resident Notes-One Resident included the following entries: -February 20, 2025, at 1:48 p.m., R5 will be discharged from hospital and R5 will be admitted to a skilled nursing facility for rehab (rehabilitation). R5 will return (to the facility) when able. -March 17, 2025, at 2:06 p.m. (after survey initiation), clinical nurse supervisor (CNS)-B entered an emergency relocation back dated to February 18, 2025. R5's record lacked a written notice (prior to	01060			

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01060	Continued From page 30 survey initiation on March 17, 2025) 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 OOLTC; - 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, R5's record lacked notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days. On March 17, 2025, at 12:45 p.m., LALD-A stated the licensee filed a Vulnerable Adult Maltreatment Report (MAARC) on February 17, 2025, regarding R5's fall and confirmation R5's right hip was fractured. On March 18, 2025, at 2:21 p.m., CNS-B stated CNS-B typically completed an emergency relocation form upon a resident leaving the facility for an emergency and provided a copy to the OOLTC if the resident had been gone from the facility for more than three days. CNS-B further stated CNS-B completed an emergency relocation form on March 17, 2025, at 2:06 p.m., for R5 after CNS-B realized an emergency relocation was missed for R5. The licensee's General Policies policy dated	01060			

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01060	Continued From page 31 August 1, 2021, indicated in the event of an emergency relocation, facility will provide a written notice to the resident, legal representative, designated representative, resident's case manager, if applicable, and the OOLTC (if the resident has not returned to the facility within four days) that contains, 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 OOLTC; -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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith	01290			

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01290	Continued From page 32 reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure background studies were affiliated with the correct health facility identification (HFID) 35519 for three of eight employees (unlicensed personnel (ULP)-C, registered nurse (RN)-G, RN-H). 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 the entrance conference on March 17, 2025, at 10:26 a.m., licensed assisted living director (LALD)-A stated the licensee was aware of the required contents of the employee record. ULP-C ULP-C was hired on December 26, 2024, to provide direct care services to residents at the assisted living facility. On March 18, 2025, from 6:34 a.m., through 7:04 a.m., the surveyor observed ULP-C interact with residents at the facility.	01290			

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01290	Continued From page 33 ULP-C's employee record contained a cleared background study notice issued by the Minnesota (MN) Department of Human Services (DHS) dated December 26, 2024. The background study was affiliated to a sister facility with the HFID 36368. On March 17, 2025, at 11:12 a.m., LALD-A provided the licensee's NETStudy 2.0 roster with HFID 35519. LALD-A stated LALD-A affiliated ULP-C to the licensee's HFID today (March 17, 2025) after the surveyor requested to view the licensee's NETStudy 2.0 roster and LALD-A had noticed ULP-C was not listed on the current NETStudy 2.0 roster. RN-G RN-G was hired on February 27, 2023, to provide RN on-call services for staff and residents at the facility. RN-G was licensed by the Minnesota Board of Nursing as an RN effective June 23, 2008. The licensee's RN On-call Schedule indicated RN-G was scheduled to be on-call March 10, 2025, through March 16, 2025. RN-H RN-H was hired on January 17, 2024, to provide RN on-call services for staff and residents at the facility. RN-H was licensed by the Minnesota Board of Nursing as an RN effective September 5, 2013. The licensee's RN On-call Schedule indicated RN-H was scheduled to be on-call March 17, 2025, through March 23, 2025.	01290			

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01290	Continued From page 34 The licensee's NETStudy 2.0 Employee Roster printed March 17, 2025, at 10:53 a.m., did not list RN-G or RN-H as current employees for the licensee. On March 18, 2025, at 9:51 a.m., LALD-A stated RN-G and RN-H were not on the licensee's NETStudy 2.0 roster HFID 35519, however, RN-G and RN-H were affiliated at sister facility locations with HFID 34980 and HFID 30498. LALD-A stated LALD-A was responsible for background study affiliations and LALD-A must have missed adding RN-G and RN-H to the licensee's NETStudy 2.0 roster. The licensee's Background Checks policy dated August 1, 2021, indicated the community (licensee) will initiate a background study on all staff given a job offer using the MN DHS NetStudy 2.0 online program. The policy did not address background study affiliation with the correct HFID. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another	01540			

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01540	Continued From page 35 employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-C) received the required amount of dementia care training in the required time frame. 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: The licensee held an assisted living with dementia care license effective May 1, 2024, with an expiration date of April 30, 2025. During the entrance conference on March 17, 2025, at 10:26 a.m., licensed assisted living director (LALD)-A stated the licensee was aware of the required contents of the employee record.	01540			

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01540	Continued From page 36 ULP-C was hired on December 26, 2024, to provide direct care services to residents at the assisted living facility. On March 18, 2025, from 6:34 a.m., through 7:04 a.m., the surveyor observed ULP-C interact with residents at the facility. ULP-C was the only staff present at the facility upon the surveyor's arrival at 6:34 a.m. ULP-C's employee transcript indicated ULP-C had completed three (3) hours of dementia training since ULP-C's hire date. ULP-C's employee record lacked the required eight (8) hours of dementia training within 80 hours of the employee's start date. On March 18, 2025, at 1:11 PM, LALD-A stated ULP-C was a current employee of the licensee and ULP-C had worked more than 80 hours. LALD-A further stated upon hire employees are assigned eight (8) hours of dementia training and ULP-C must not have completed all the required and assigned dementia training. The licensee's Alzheimer's Disease and Related Disorders- Training and Notification policy dated August 1, 2021, indicated direct care staff ULPs must have completed at least eight (8) hours of initial training within 80 hours of the employment start date. Until this initial (dementia) training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. No further information was provided.	01540			

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01540	Continued From page 37	01540			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
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 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 the service plan included a licensee signature or other authentication by the licensee and by the resident to document agreement on the services to be provided for one of two residents (R2). This practice resulted in a level two violation (a	01640			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01640	Continued From page 38 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: During the entrance conference on March 17, 2025, at 10:14 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. R2's diagnoses included hypertension (high blood pressure). On March 18, 2025, at 7:36 a.m., the surveyor observed unlicensed personnel (ULP)-F provide scheduled morning medication administration to R2. R2's Service Plan dated March 19, 2025 (two days after survey initiation), indicated R2 received medication administration, behavior management, and assistance with bathing, grooming, dressing, laundry, and light housekeeping. R2's service plan lacked a licensee signature or other authentication by the licensee and by the resident to document agreement on the services to be provided. On March 19, 2025, at 2:15 p.m., LALD-A emailed (electronic mail) LALD-A was unable to locate a signed service plan for R2.	01640			

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01640	Continued From page 39 On March 19, 2025, at 2:54 p.m., clinical nurse supervisor (CNS)-B stated CNS-B recalled R2's wife signing R2's service plan, however, CNS-B was unable to locate the R2's signed service plan in R2's record. CNS-B further stated CNS-B reviewed resident service plans with the resident or resident's representative and would have them sign the service plans after the review. The licensee's Service Plan policy dated August 1, 2021, indicated the service plan and any revisions shall include a signature or other authentication by This [sic] community (licensee) and by the resident, or resident's representative, documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident.	01750			

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01750	Continued From page 40 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an unlicensed personnel (ULP) had demonstrated the ability to competently follow the procedures for administering medications to a registered nurse (RN) for one of three employees (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, 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 17, 2025, at 10:17 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. ULP-E was hired on May 7, 2024, to provide direct care services to residents at the assisted living facility. ULP-E's My Transcript printed on March 18, 2025, at 9:32 a.m., indicated ULP-E completed training on Medication Administration- Routes on May 16, 2024. ULP-E's Assisted Living Training and Competencies Manual dated May 23, 2024, indicated ULP-E had completed medication administration training, including topical medications, however, all routes of medication	01750			

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01750	Continued From page 41 administration competencies were "NA" (not applicable) as ULP-E did not want to do medication administration for residents. On March 18, 2025, at 7:08 a.m., ULP-E entered the locked medication room and took R4's prescribed Desenex antifungal powder from the counter. ULP-E went to R4's room and assisted R4 with toileting, dressing, and transfers. At 7:32 a.m., the surveyor observed ULP-E administer R4's Desenex antifungal powder to R4's groin. ULP-E's employee record lacked evidence which indicated ULP-E was deemed competent to provide topical medication administration. On March 18, 2025, at 9:28 a.m., licensed assisted living director (LALD)-A stated when ULP-E was hired by the licensee, ULP-E indicated ULP-E did not want to provide medication administration to residents. On March 18, 2025, at 10:13 a.m., ULP-E stated ULP-E did not administer resident medications. ULP-E further stated ULP-E did not realize R4's topical powder (antifungal powder) was considered part of R4's scheduled medication administration. On March 18, 2025, at 10:19 a.m., CNS-B stated ULP-E was not competency tested to administer any medications, including topical medications, as ULP-E was supposed to only provide resident cares. CNS-B further stated a ULP must be trained and deemed competent to administer medications by an RN prior to administering any prescriptions or over the counter medications. The licensee's Training and Competency Evaluations for ULP policy dated August 1, 2021,	01750			

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01750	Continued From page 42 indicated only unlicensed personnel who are determined to be competent and possess the knowledge and skills consistent with the complexity of tasks being delegated will be permitted to perform such delegated tasks, including medication administration. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01750			
01760 SS=G	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 by: Based on interview and record review, the licensee failed to ensure medications were readily available to administer as ordered for one of three residents (R1). This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	01760			

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01760	Continued From page 43 not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on March 17, 2025, at 10:17 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. The licensee's Discharged Resident/Client Roster dated March 17, 2025, indicated R1 was admitted to the assisted living on February 6, 2024, and R1 was discharged to a nursing home on March 6, 2025. R1's diagnoses included Alzheimer's Disease, hypertension (HTN-high blood pressure), and diabetes. R1's service plan dated January 1, 2025, indicated R1 received medication administration six times per day. R1's Assessment dated January 28, 2025, indicated the licensed practical nurse (LPN) or registered nurse (RN) were responsible for monitoring medication supplies and reordering as needed. In addition, the assessment indicated nurse was available to staff either while on site and/or available via phone for unlicensed staff to contact with questions or concerns regarding medications, supplies, or resident cares/services [sic].	01760			

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01760	Continued From page 44 R1's prescriber orders dated October 23, 2024, included the following medications: -Apixaban (anticoagulant-blood thinner) 2.5 milligrams (mg) twice per day -digoxin (to treat congestive heart failure) 0.125 mg daily -metoprolol (antihypertensive) 75 mg twice per day -Tamsulosin Hcl (for improved urination) 0.4 mg daily -metformin (to treat diabetes) 2,000 mg daily -Mirtazapine (antidepressant) 22.5 mg daily -gabapentin (for neuropathy) 300 mg daily R1's Med (medication) Admin (administration) Summary- Actual-Month dated February 2025 indicated the following: -February 6, 7, 8, 9, 10, 11, 12, and 13, respectively, R1 did not receive Apixaban 2.5 mg dose scheduled at 8:00 a.m.; -February 7, 8, 9, 10, 11, and 13, respectively, R1 did not receive digoxin 0.125 mg dose scheduled at 8:00 a.m.; -February 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, and 28, respectively, R1 did not receive metoprolol 75 mg dose scheduled at 8:00 a.m.; -February 1, 2, 3, 4, 5, and 6, respectively, R1 did not receive Tamsulosin Hcl 0.4 mg dose scheduled at 8:00 a.m.; -February 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, and 28, respectively, R1 did not receive metformin 2,000 mg dose scheduled at 8:00 p.m.; -February 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, and 28, respectively, R1 did not receive metoprolol 75 mg dose scheduled at 8:00 p.m.; -February 5, 6, 7, 8, 9, 10, 11, and 12, respectively, R1 did not receive Apixaban 2.5 mg	01760			

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01760	Continued From page 45 dose scheduled at 8:00 p.m.; -February 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, and 28, respectively, R1 did not receive gabapentin 300 mg dose scheduled at 8:00 p.m.; and -February 1, 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 20, 21, 22, 23, 24, and 25, respectively, R1 did not receive Mirtazapine 22.5 mg dose scheduled at 8:00 p.m. R1's Med (medication) Admin (administration) Summary- Actual-Month dated March 2025 indicated the following: -March 1, and 2, respectively, R1 did not receive metoprolol 75 mg dose scheduled at 8:00 a.m.; -March 1, 2, 3, 4, and 5 respectively, R1 did not receive metformin 2,000 mg dose scheduled at 8:00 p.m.; -March 1, and 2, respectively, R1 did not receive metoprolol 75 mg dose scheduled at 8:00 p.m.; and -March 1, 2, 3, 4, and 5, respectively, R1 did not receive gabapentin 300 mg dose scheduled at 8:00 p.m. Unlicensed personnel (ULPs) documented the above noted medications as not administered to R1 due to skipped medication out of stock- nurse notified, medication not available, or medication on order. R1's Medication Reorders dated November 25, 2024, indicated the licensee sent a fax to R1's pharmacy requesting medication refills, which included Apixaban 2.5 mg, metformin 500 mg tablets, and Tamsulosin Hcl 0.4 mg. R1's Medication Reorders dated January 31, 2025, indicated the licensee sent a fax to R1's pharmacy requesting medication refills, which	01760			

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01760	Continued From page 46 included Apixaban 2.5 mg, digoxin 0.125 mg, and Tamsulosin Hcl 0.4 mg. R1's Medication Reorders dated February 17, 2025, indicated the licensee sent a fax to R1's pharmacy requesting medication refills, which included Apixaban 2.5 mg, gabapentin 300 mg, metformin 500 mg tablets, metoprolol 25 mg tablets, and Mirtazapine 7.5 mg tablets. R1's record lacked documentation of any follow-up procedures or interventions that were provided to meet R1's needs when medication was not available to be given to R1. In addition, R1's record lacked documentation, which notified R1's physician of prescribed medications not administered to R1. On March 18, 2025, at 6:34 a.m., ULP-C stated when a resident is out of medication, ULPs document in the resident's electronic medication administration record (EMAR) to indicate the medication is out of stock and notify the nurse. On March 19, 2025, from 2:41 p.m., CNS-B stated CNS-B was responsible for all resident medication refills. CNS-B stated R1's medications noted above were all prescribed by R1's physician and CNS-B considered the medications critical for R1 to take due to R1's health. CNS-B stated CNS-B had faxed requested medication refills on November 25, 2024, January 31, 2025, and February 17, 2025, respectively, as noted above. CNS-B stated the pharmacy would send medications that were not listed on the medication refill form and CNS-B stated the pharmacy was very frustrating to deal with. CNS-B further stated CNS-B did not put any additional interventions in place to monitor for health changes in R1 due to R1 not receiving	01760			

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01760	Continued From page 47 R1's prescribed medications, and CNS-B did not recall notifying R1's family or physician of medication not being available to administer to R1. The licensee's Medication Record-Documentation policy dated August 1, 2021, indicated if medication assistance was not completed as prescribed, documentation must include the reason why it was not completed and any follow up procedures that were provided. The licensee's Medication and Supplies-Reordering policy dated August 1, 2021, indicated if a resident needs a medication(s) reordered from the pharmacy, staff will contact the pharmacy by faxing the prescription refill. In addition, when the pharmacy is unable to refill a prescription(s) for any particular reason; this is communicated to the nursing staff immediately. Nursing staff will inform the resident's primary Care Provider [sic], either by phone or fax, and make a nursing note entry into the resident's chart indicating the communication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced	01880			

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01880	Continued From page 48 by: Based on observation, interview, and record review, the licensee failed to ensure one of one refrigerator storing medications maintained an acceptable temperature and medications were stored according to manufacturer's recommended temperature. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 17, 2025, at 10:17 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. During the facility tour on March 17, 2025, at 10:59 a.m., CNS-B stated the medication refrigerator's current temperature, located in the locked medication room, was 40 degrees Fahrenheit (F). CNS-B further stated the medication refrigerator temperature was checked every night by ULPs. The medication refrigerator contained two unopened Novolog 100 units/ milliliter (mL) insulin FlexPens for R2. The licensee's Chore Recap by Specific Chore dated February 1, 2025, through March 17, 2025, indicated to check temp (temperature) of fridge in med (medication) room and document every PM (evening) shift. The Chore Recap by Specific Chore indicated nine (9) out of 44 opportunities	01880			

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01880	Continued From page 49 the medication refrigerator temperature was not checked or documented. On March 17, 2025, at 1:12 p.m., licensed assisted living director (LALD)-A stated ULPs were trained to check the medication refrigerator temperature daily and ULPs failed to document on the medication refrigerator temperature nine times since February 1, 2025. On March 17, 2025, at 2:11 p.m., CNS-B stated ULPs were to check the medication refrigerator temperature every night to ensure medications were stored per manufacturer instructions, notify CNS-B if the temperature was out of range, and document the temperature of the medication refrigerator. The manufacturer's instructions for Novolog dated October 2021, indicated to store unopened Novolog FlexPens in the refrigerator at 36 degrees F to 46 degrees F. Do not allow Novolog to freeze. The licensee's Storage of Medications policy dated August 1, 2021, indicated medications shall be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
02120 SS=D	144G.83 Subdivision 1 General (a) An assisted living facility with dementia care must provide residents with dementia-trained	02120			

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02120	Continued From page 50 staff who have been instructed in the person-centered care approach. All direct care staff assigned to care for residents with dementia must be specially trained to work with residents with Alzheimer's disease and other dementias. (b) Only staff trained as specified in subdivisions 2 and 3 shall be assigned to care for dementia residents. (c) Staffing levels must be sufficient to meet the scheduled and unscheduled needs of residents. Staffing levels during nighttime hours shall be based on the sleep patterns and needs of residents. (d) In an emergency situation when trained staff are not available to provide services, the facility may assign staff who have not completed the required training. The particular emergency situation must be documented and must address: (1) the nature of the emergency; (2) how long the emergency lasted; and (3) the names and positions of staff that provided coverage. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff working in the dementia care unit were trained in a person-centered care approach for one of two employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).	02120			

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02120	Continued From page 51 The findings include: The licensee held an assisted living with dementia care license effective May 1, 2024, with an expiration date of April 30, 2025. During the entrance conference on March 17, 2025, at 10:14 a.m. licensed assisted living director (LALD)-A stated the licensee was licensed as an assisted living with dementia care and the entire building was a secured (required assistance by staff or keypad to enter and exit) dementia unit. During the entrance conference on March 17, 2025, at 10:26 a.m., LALD-A stated the licensee was aware of the required contents of the employee record. LALD-A further stated the licensee staffed one ULP from 11:00 p.m. until 7:00 a.m., every night. ULP-C was hired on December 26, 2024, to provide direct care services to residents at the assisted living facility. On March 18, 2025, from 6:34 a.m., through 7:04 a.m., the surveyor observed ULP-C interact with residents at the facility. ULP-C was the only staff present at the facility upon the surveyor's arrival at 6:34 a.m. ULP-C's employee transcript indicated ULP-C had completed three (3) hours of dementia training since ULP-C's hire date. The licensee lacked evidence of another employee on site who completed the initial eight hours of dementia training for ULP-C to use as a resource and assist if issues arose.	02120			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER TWIN VALLEY ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 208 OPPEGARD AVENUE NW TWIN VALLEY, MN 56584		
(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
02120	Continued From page 52 On March 18, 2025, at 1:11 p.m., LALD-A stated ULP-C was a current employee of the licensee and ULP-C had worked more than 80 hours. LALD-A further stated upon hire employees are assigned eight (8) hours of dementia training and ULP-C must not have completed all the required and assigned dementia training. The licensee's Alzheimer's Disease and Related Disorders- Training and Notification policy dated August 1, 2021, indicated direct care staff ULPs must have completed at least eight (8) hours of initial training within 80 hours of the employment start date. Until this initial (dementia) training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 3, effective October 2022, in addition to the other training requirements identified in Subp. 1, direct care dementia-trained staff under Minnesota Statutes, section 144G.83, Subp. 1, and other staff having direct contact with residents of a facility that has an assisted living facility with dementia care license must receive training on the following topics: (1) understanding cognitive impairment, and behavioral and psychological symptoms of dementia; and (2) standards of dementia care, including nonpharmacological dementia care practices that are person-centered and evidence-informed. No further information was provided.	02120			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER TWIN VALLEY ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 208 OPPEGARD AVENUE NW TWIN VALLEY, MN 56584			
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02120	Continued From page 53	02120			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the steps of the medication administration process was followed for one of one employee (unlicensed personnel (ULP)-F) observed administering medications. 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: During the entrance conference on March 17, 2025, at 10:17 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility.	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER TWIN VALLEY ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 208 OPPEGARD AVENUE NW TWIN VALLEY, MN 56584		
(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
02320	Continued From page 54 R6's diagnoses included chronic obstructive pulmonary disease (COPD- difficult breathing). R6's Service Plan dated October 11, 2024, indicated R6 received medication administration six times per day. R6's prescriber orders dated February 14, 2025, included an order for Breo Ellipta 200-25 micrograms (mcg)/dose inhaler- inhale one puff orally one time per day and rinse mouth after. R6's Med (medication) Admin (administration) Summary-Month dated March 2025, indicated Breo Ellipta 200-25 mcg inhaler- inhale one puff orally one time per day and rinse mouth with water after use. On March 18, 2025, at 8:10 a.m., the surveyor observed ULP-F provide scheduled morning medication administration for R6. ULP-F handed R6 the Breo Ellipta inhaler for self- administration, R6 inhaled one puff from the Breo Ellipta inhaler, and R6 returned the Breo Ellipta inhaler back to ULP-F. ULP-F handed R6's morning oral medications along with a glass of water to R6, R6 took the oral medications, and swallowed the water. The surveyor did not observe ULP-F offer R6 water to rinse and spit after inhalation of the Breo Ellipta inhaler. On March 18, 2025, at 12:38 p.m., ULP-F stated R6 had always refused to rinse and spit mouth after the use of R6's inhaler, so ULP-F did not offer R6 to rinse and spit after the Breo Ellipta inhaler administration. On March 18, 2025, at 12:42 p.m., CNS-B stated ULPs were trained to follow specific instructions	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER TWIN VALLEY ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 208 OPPEGARD AVENUE NW TWIN VALLEY, MN 56584		
(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
02320	Continued From page 55 listed on the electronic medication administration record (EMAR) and R6 should have been offered water to rinse and spit after the use of R6's Breo Ellipta inhaler. The manufacturer's instructions for Breo Ellipta dated July 2021, indicated to rinse mouth with water after you have used the inhaler and spit the water out. Do not swallow the water. The licensee's Medication Administration-Procedure policy dated August 1, 2021, indicated after an inhaler is administered staff to offer/provide [sic] a drink to rinse mouth after use. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320			

Type: Follow-Up
Date: 03/26/25
Time: 10:45:00
Report: 1049251064

Food and Beverage Establishment Inspection Report

Page 1

Location:

Twin Valley Assisted Living
208 Oppegard Avenue Nw
Twin Valley, MN56584
Norman County, 54

Establishment Info:

ID #: 0039317
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2185845181
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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Chlorine: = 50 PPM at Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

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

Things to Remember:

1. The Certified Food Manager should be routinely conducting self inspections to ensure that employees are following proper food handling practices.
2. Educate employees on the importance of reporting to management any illness they have or have had recently. Management should exclude any workers ill with vomiting or diarrhea from handling food, and they should keep an up to date employee illness log.
3. There should be a Person in Charge at the establishment during all hours of operation. This person should ensure that employees are practicing good hand washing procedures, including being knowledgeable about when hand washing should be done and how to properly wash hands.
4. Employees should use spatula, tongs, deli tissue, gloves, or some other approved means to prevent any direct bare hand contact with ready to eat foods.

Type: Follow-Up

Date: 03/26/25

Time: 10:45:00

Report: 1049251064

Twin Valley Assisted Living

Food and Beverage Establishment Inspection Report

Page 2

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 1049251064 of 03/26/25.

Certified Food Protection Manager Melinda Wold

Certification Number: FM109196 Expires: 01/14/28

Signed: _____

Establishment Representative

Signed: Stephanie Reynolds

Stephanie Reynolds
Public Health Sanitarian
Fergus Falls
218-332-5179
stephanie.reynolds@state.mn.us

Type: Full
Date: 03/18/25
Time: 11:30:00
Report: 1049251056

Food and Beverage Establishment Inspection Report

Page 1

Location:

Twin Valley Assisted Living
208 Oppegard Avenue Nw
Twin Valley, MN56584
Norman County, 54

Establishment Info:

ID #: 0039317
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2185845181
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.

4-700 Sanitizing Equipment and Utensils

4-702.11 **** Priority 1 ****

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.
THE DISH MACHINE TESTED AT 10 PPM CHLORINE. THE BUCKET OF SANITIZER WAS LOW; PIC IS OBTAINING MORE SANITIZER. PIC INSTRUCTED TO UTILIZE THE 3-COMPARTMENT SINK UNTIL MORE SANITIZER ARRIVES AND THE DISH MACHINE TESTS BETWEEN 50 AND 100 PPM.

Comply By: 03/18/25

Surface and Equipment Sanitizers

Chlorine: = 10 PPM at Degrees Fahrenheit
Location: Dish Machine
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: Walk-In Cooler
Temperature: 34.5 Degrees Fahrenheit - Location: Lettuce
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 33.5 Degrees Fahrenheit - Location: Milk
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 35.5 Degrees Fahrenheit - Location: Shredded Cheese
Violation Issued: No

Type: Full
Date: 03/18/25
Time: 11:30:00
Report: 1049251056
Twin Valley Assisted Living

Food and Beverage Establishment Inspection Report

Page 2

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: Lettuce
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: Cheese Sticks
Violation Issued: No

Process/Item: Re-Heating
Temperature: 166.5 Degrees Fahrenheit - Location: Taco Meat
Violation Issued: No

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

INSPECTOR MET WITH ESTABLISHMENT REPRESENTATIVE AND MDH NURSE EVALUATOR.

ESTABLISHMENT CURRENTLY UTILIZES THE DOMESTIC KITCHEN TO COOK AND SERVE FROM. HOWEVER, THE ESTABLISHMENT UTILIZES THE COMMERCIAL KITCHEN'S DISH MACHINE TO WASH DISHES AND UTENSILS.

THE DOMESTIC KITCHEN HAS PAINTED WALLS AND PAINTED CEILING, TILE FLOORING, LAMINATE COUNTERTOPS, AND WOOD CUPBOARDS.

Things to Remember:

1. The Certified Food Manager should be routinely conducting self inspections to ensure that employees are following proper food handling practices.
2. Educate employees on the importance of reporting to management any illness they have or have had recently. Management should exclude any workers ill with vomiting or diarrhea from handling food, and they should keep an up to date employee illness log.
3. There should be a Person in Charge at the establishment during all hours of operation. This person should ensure that employees are practicing good hand washing procedures, including being knowledgeable about when hand washing should be done and how to properly wash hands.
4. Employees should use spatula, tongs, deli tissue, gloves, or some other approved means to prevent any direct bare hand contact with ready to eat foods.

Type: Full
Date: 03/18/25
Time: 11:30:00
Report: 1049251056
Twin Valley Assisted Living

Food and Beverage Establishment Inspection Report

Page 3

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 1049251056 of 03/18/25.

Certified Food Protection Manager Melinda Wold

Certification Number: FM 109196 Expires: 01/14/28

Signed: _____

Establishment Representative

Signed: Stephanie Reynolds

Stephanie Reynolds
Public Health Sanitarian
Fergus Falls
218-332-5179
stephanie.reynolds@state.mn.us

Report #: 1049251056

DEPARTMENT OF HEALTH

Minnesota Department of Health

Fergus Falls District

2312 College Way

Fergus Falls

No. of RF/PHI Categories Out

1

Date

03/18/25

No. of Repeat RF/PHI Categories Out

0

Time In

11:30:00

Legal Authority MN Rules Chapter 4626

Time Out

Twin Valley Assisted Living

Address

208 Oppegard Avenue Nw

City/State

Twin Valley, MN

Zip Code

56584

Telephone

2185845181

License/Permit #

0039317

Permit Holder

Purpose of Inspection

Full

Est Type

Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item

Mark "X" in appropriate box for COS and/or R

IN=in compliance

OUT= not in compliance

N/O= not observed

N/A= not applicable

COS=corrected on-site during inspection

R= repeat violation

Compliance Status

COS

R

Supervision

1

IN

OUT

PIC knowledgeable; duties & oversight

2

IN

OUT

N/A

Certified food protection manager, duties

Employee Health

3

IN

OUT

Mgmt/Staff;knowledge,responsibilities&reporting

4

IN

OUT

Proper use of reporting, restriction & exclusion

5

IN

OUT

Procedures for responding to vomiting & diarrheal events

Good Hygienic Practices

6

IN

OUT

N/O

Proper eating, tasting, drinking, or tobacco use

7

IN

OUT

N/O

No discharge from eyes, nose, & mouth

Preventing Contamination by Hands

8

IN

OUT

N/O

Hands clean & properly washed

9

IN

OUT

N/A

N/O

No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed

10

IN

OUT

Adequate handwashing sinks supplied/accessible

Approved Source

11

IN

OUT

Food obtained from approved source

12

IN

OUT

N/A

N/O

Food received at proper temperature

13

IN

OUT

Food in good condition, safe, & unadulterated

14

IN

OUT

N/A

N/O

Required records available; shellstock tags, parasite destruction

Protection from Contamination

15

IN

OUT

N/A

N/O

Food separated and protected

16

IN

OUT

N/A

Food contact surfaces: cleaned & sanitized

17

IN

OUT

Proper disposition of returned, previously served, reconditioned, & unsafe food

Compliance Status

COS

R

Time/Temperature Control for Safety

18

IN

OUT

N/A

N/O

Proper cooking time & temperature

19

IN

OUT

N/A

N/O

Proper reheating procedures for hot holding

20

IN

OUT

N/A

N/O

Proper cooling time & temperature

21

IN

OUT

N/A

N/O

Proper hot holding temperatures

22

IN

OUT

N/A

Proper cold holding temperatures

23

IN

OUT

N/A

N/O

Proper date marking & disposition

24

IN

OUT

N/A

N/O

Time as a public health control: procedures & records

Consumer Advisory

25

IN

OUT

N/A

Consumer advisory provided for raw/undercooked food

Highly Susceptible Populations

26

IN

OUT

N/A

Pasteurized foods used; prohibited foods not offered

Food and Color Additives and Toxic Substances

27

IN

OUT

N/A

Food additives: approved & properly used

28

IN

OUT

Toxic substances properly identified, stored, & used

Conformance with Approved Procedures

29

IN

OUT

N/A

Compliance with variance/specialized process/HACCP

Risk factors(RF) are improper practices or proceeedures identified as the most prevalent contributing factors of foodborne illness or injury .Public Health Interventions (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is not in compliance

Mark "X" in appropriate box for COS and/or R

COS=corrected on-site during inspection

R= repeat violation

COS

R

Safe Food and Water

30

IN

OUT

N/A

Pasteurized eggs used where required

31

Water & ice obtained from an approved source

32

IN

OUT

N/A

Variance obtained for specialized processing methods

Food Temperature Control

33

Proper cooling methods used; adequate equipment for temperature control

34

IN

OUT

N/A

N/O

Plant food properly cooked for hot holding

35

IN

OUT

N/A

N/O

Approved thawing methods used

36

Thermometers provided & accurate

Food Identification

37

Food properly labled; original container

Prevention of Food Contamination

38

Insects, rodents, & animals not present

39

Contamination prevented during food prep, storage & display

40

Personal cleanliness

41

Wiping cloths: properly used & stored

42

Washing fruits & vegetables

Proper Use of Utensils

43

In-use utensils: properly stored

44

Utensils, equipment & linens: properly stored, dried, & handled

45

Single-use/single service articles: properly stored & used

46

Gloves used properly

Utensil Equipment and Vending

47

Food & non-food contact surfaces cleanable, properly designed, constructed, & used

48

Warewashing facilities: installed, maintained, & used; test strips

49

Non-food contact surfaces clean

Physical Facilities

50

Hot & cold water available; adequate pressure

51

Plumbing installed; proper backflow devices

52

Sewage & waste water properly disposed

53

Toilet facilities: properly constructed, supplied, & cleaned

54

Garbage & refuse properly disposed; facilities maintained

55

Physical facilities installed, maintained, & clean

56

Adequate ventilation & lighting; designated areas used

57

Compliance with MCIAA

58

Compliance with licensing & plan review

Food Recalls:

Person in Charge (Signature)

Date:

03/18/25

Inspector (Signature)

Stephanie Reynolds