Electronically delivered

May 5, 2022

Administrator
Valleyview Assisted Living
1212 West Frontage Road
Owatonna, MN 55060

RE: Project Number(s) SL25302015

Dear Administrator:

On April 27, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on February 10, 2022. The follow-up evaluation determined your agency had not corrected all of the state licensing orders issued pursuant to the February 10, 2022 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on February 10, 2022, found not corrected at the time of the April 27, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

1350-Temporary Staff-144g.60 Subd. 5

The details of the violations noted at the time of this follow-up evaluation completed on April 27, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

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.

CORRECTION ORDER RECONSIDERATION PROCESS

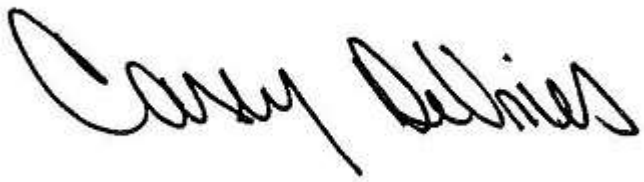
In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

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

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,



Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25302	A. BUILDING: _____ B. WING _____	R 04/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEYVIEW ASSISTED LIVING	1212 WEST FRONTAGE ROAD OWATONNA, MN 55060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: Project # SL25302015-1 On April 26, and April 27, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on February 10, 2022. At the time of the survey, there were 59 residents receiving services under the Assisted Living license. As a result of the revisit, the following order was reissued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	{0 480}		

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{0 480}	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) 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 following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action is required.	{0 480}		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;	{0 780}		

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{0 780}	Continued From page 2 (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: No further action is required.	{0 780}		
{0 790} SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: No further action is required.	{0 790}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including	{0 800}		

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{0 800}	Continued From page 3 walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: No further action is required.	{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) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at	{0 810}		

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{0 810}	Continued From page 4 least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action is required.	{0 810}		
{01350} SS=E	144G.60 Subd. 5 Temporary staff When a facility contracts with a temporary staffing agency, those individuals must meet the same requirements required by this section for personnel employed by the facility and shall be treated as if they are staff of the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure contracted staff utilized by the licensee met all orientation requirements as if employed by the facility for three of five unlicensed personnel ((ULP)-G, ULP-H and ULP-J) with employee records reviewed. In addition, the licensee failed to ensure contracted staff utilized by the licensee were competency tested prior to performing delegated tasks and were supervised by the registered nurse as required for two of five unlicensed personnel (ULP-H and ULP-J) with employee records reviewed. 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	{01350}		

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{01350}	Continued From page 5 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference April 26, 2022, at approximately 11:44 a.m., clinical director/registered nurse (RN)-A, confirmed the licensee utilized contracted employees to maintain staffing for the facility from three different staffing agencies. RN-A also verified the licensee used unlicensed personnel (ULP) to provide resident services such as dressing, making beds, toileting, in addition to delegated nursing tasks such as medication administration and treatments including compression stockings, ACE wraps, oxygen management, obtaining blood glucose levels and application of orthotic braces (prescribed medical device worn on the body to correct problems such as how one walks or stands). LACK OF EVIDENCE OF ORIENTATION TO ASSISTED LIVING ULP-G ULP-G was contracted on November 30, 2021, to provide direct care services to the licensee's residents. ULP-H ULP-H was contracted on February 2, 2021, to provide direct care services to the licensee's residents.	{01350}		

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{01350}	Continued From page 6 ULP-J ULP-J was contracted on February 3, 2022, to provide direct care services to the licensee's residents. ULP-G's, ULP-H's and ULP-J's employee files lacked evidence of having completed orientation to assisted living to include the following required content: -overview of assisted living statutes; -introduction and review of the provider's policies and procedures related to the provision of AL services; -handling of emergencies and use of emergency services; -compliance with reporting of maltreatment of vulnerable adults; -assisted living bill of rights; -handling of resident complaints, reporting of complaints, and where to report; -consumer advocacy services; -principles of person-centered planning and service delivery; and -review of the types of assisted living services the employee will be providing and the facility's category of license. On April 27, 2022, at approximately 12:29 p.m., RN-A indicated she was newly hired to oversee the clinical side at the facility and had completed some employee training in response to the survey completed in February. RN-A stated the nurse who was present and in charge during the prior survey had not completed all corrections from that survey and said she was trying to sort out what still needed to be done. RN-A said the assisted living orientation for agency staff "likely" was not complete. LACK OF EVIDENCE OF SKILLS	{01350}		

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{01350}	Continued From page 7 COMPETENCIES & SUPERVISION ULP-G's and ULP-J's training records lacked evidence the RN tested and documented skill competency for these agency staff who performed delegated nursing tasks including: -compression stockings; -ACE wraps; -orthotics; and -oxygen use. Additionally, ULP-G's and ULP-J's employee files lacked evidence the RN supervised the ULPs within 30 days of performing delegated tasks, as required. On April 27, 2022, RN-A stated they understood the licensee needed to have documentation that agency/pool staff were competent to perform delegated tasks. RN-A also expressed understanding the registered nurse needed to make supervisory observations of all unlicensed staff performing delegated tasks and have documentation in the employees' files. RN-A said this had not been corrected. Later at 2:12 p.m., the regional director/registered nurse (RN)-K acknowledged this deficiency "probably was not done." The licensee's 4.07 Temporary and Contracted Staff policy dated August 1, 2021, indicated temporary supplemental staffing or contracted staff would only be used if they met the same requirements required as hired employees and would be treated as if they were staff of the facility. The licensee's 5.01 Orientation of Staff and Supervisors & Content policy dated August 1, 2021, indicated all staff of Valleyview of	{01350}		

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{01350}	Continued From page 8 Owatonna providing and supervising direct care services must complete an orientation of Assisted Living facility licensing requirements and regulations before providing assisted living services to residents. The licensee's 5.02 Competency Training Evaluations policy dated August 1, 2021, indicated when a RN of Valleyview of Owatonna delegates tasks, prior to the delegation of services the RN must make certain the ULP was trained in the proper methods to perform the tasks or procedures and able to demonstrate the ability to competently follow the procedures and perform the tasks. The policy also indicated a copy of all education, training and competency testing shall be kept in each employee's personnel file. The licensee's 6.17 Supervision of Staff - Delegated Services policy, dated August 1, 2021, indicated staff who provide delegated nursing or therapy tasks to residents at Valleyview of Owatonna would be supervised by an RN. Further, the direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for Valleyview and first performs delegated tasks for residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	{01350}		

Electronically Delivered

March 7, 2022

Administrator
Valleyview Assisted Living
1212 West Frontage Road
Owatonna, MN 55060

RE: Project Number(s) SL25302015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on February 11, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

The enclosed State Form documents the state licensing orders. The Department of Health 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 imposed immediately with no opportunity to correct the violation first as follows:

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

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

The total amount you are assessed is $3,000.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The licensee is not required to submit a plan of correction 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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 000	Initial Comments Initial comments *****ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.09 to 144G.95, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: Project # SL25302015 On February 7, 2022, through February 10, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 59 residents receiving services under the provider's Assisted Living license. An immediate correction order was identified on February 8, 2022, issued for SL25302015, tag identification 2310. *REVISED* Immediate correction order, tag identification 2310 was originally cited at a scope and level of "I". Upon further review, the scope and level of "I" is recinded and tag identification 2310 is assigned a scope and level of "G".	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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	25302	A. BUILDING: _____ B. WING _____	02/11/2022

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0 000	Continued From page 1 On February 9, 2022 the immediacy of correction order 2310 was removed, however non-compliance remains at a scope and level of G.	0 000		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) 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 following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 480		

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0 480	Continued From page 2 or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated February 9, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=E	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure infection control standards were followed after using a shared glucometer (device used to measure blood sugar levels) for two of two unlicensed personnel ((ULP)-G, ULP-H) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 510		

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0 510	Continued From page 3 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On February 7, 2022, at approximately 4:13 p.m., the surveyor observed unlicensed personnel (ULP)-G set up supplies and equipment to test R1's blood sugar. ULP-G was unable to use R1's glucometer because ULP-G could not find the corresponding test strips. Instead, ULP-G opened utilized the facility's house (shared) glucometer. After obtaining the blood sample and tests results from R1, ULP-G placed the glucometer back into the storage pouch from where it was obtained, without cleaning it. On February 7, 2022, at approximately 4:20 p.m., ULP-G verified she did not cleanse the glucometer following its use. ULP-G then retrieved the house glucometer and pulled a disposable, germicidal wipe from a container on top of the medication cart, labeled "Super Sani-Cloth." ULP-G used the cloth to wipe the glucometer but did not thoroughly wet or wrap the glucometer to allow for sufficient contact time with the wipe to ensure cleansing or allow to air dry after being wet. ULP-G stated this was how she cleaned the glucometer and other equipment such as oximeter or a blood pressure cuff, between resident use. On February 8, 2022, at approximately 8:01 a.m., ULP-H attempted to obtain a blood sugar from R3	0 510		

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0 510	Continued From page 4 using the resident's glucometer, but was unsuccessful and decided to use the house glucometer. Before putting the house glucometer back into its storage pouch, ULP-H pulled a wipe from the purple top container "Sani-Cloth" germicidal wipes, quickly wiped the glucometer and immediately placed it back into its pouch container. ULP-H did not thoroughly wet or wrap the glucometer to allow for sufficient contact time with the wipe to ensure cleansing or allow to air dry after being wet. On February 8, 2022, at approximately 8:05 a.m., ULP-H stated she wiped down the glucometer, and verified she did not really get it wet or wrap it up in the cloth for any length of time. ULP-H stated she only wiped it off and did not know about contact time or allowing dry time to clean the glucometer. On February 9, 2022, at approximately 8:41 a.m., registered nurse (RN)-C stated staff were trained to use the cleaning cloths to wipe down equipment, but acknowledged they were not wetting or wrapping the glucometer up to allow contact time and drying time for the cleansing to be effective. RN-C stated she was alerted to the issue from floor staff and would do re-education. RN-C also stated each resident had their own glucometer and staff should be using those, but that if a shared device was used, it needed to be thoroughly cleaned between resident use. RN-C said that would also be the expectation for cleaning other shared devices. The licensee's Infection Control, 8.03 Cleaning of Shared Medical Equipment policy, dated August 1, 2021, indicated the licensee would implement and maintain processes to ensure reusable care equipment is routinely cleaned and when	0 510		

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0 510	Continued From page 5 appropriate, disinfected before and after reuse. The policy indicated glucometers used by multiple residents must be cleaned and disinfected and directed to follow disinfection product instructions to make sure it is applied properly and remained on the glucometer for the required amount of time (typically two minutes). Manufacturer's label for "Sani-Cloth" germicidal, disposable wipes indicated the product was bactericidal, tuberculocidal and virucidal in two minutes. To disinfect and deodorize, the label directed to unfold clean wipe, and thoroughly wet the surface and allow treated surface to remain wet for two minutes and let air dry. No further information was provided. TIME PERIOD FOR CORRECTION: seven (7) days.	0 510		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding	0 680		

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0 680	Continued From page 6 missing tenant 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 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 observation, interview and record review, the licensee failed to have a written emergency preparedness (EP) plan that included all required content. This had the potential to affect all 59 current residents in the facility, staff and any 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 February 7, 2022, at approximately 12:17 p.m., the surveyor made a request to licensed assisted living director (LALD)-A to view the licensee's emergency preparedness (EP) plan. On February 7, 2022, during a tour of the facility	0 680		

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0 680	Continued From page 7 at approximately 12:30 p.m., the surveyor observed in the hallways, near the main entrance and near the elevator, signage that diagrammed emergency exits from the building. Also near the front entrance was a sign with the R-A-C-E procedures (an acronym for fires emergency: rescue, alarm, confine and extinguish); and a procedure titled "Severe Weather Related to Rain Storm or Tornado" dated April 12, 2012. There was no posted information regarding an emergency preparedness plan. The licensee's emergency preparedness (EP) plan, dated August 1, 2021, was presented in a three-ring binder which included a hazard/vulnerability tool, numerous required policies, various contact lists, a communication plan, agreements with other facilities and other, general emergency-related information. However, the EP document lacked required content as identified in Appendix Z, the state-adopted rule addressing emergency preparedness. The licensee's plan lacked the following: -assessment of the patient population; -subsistence needs for staff and residents during emergency situation; -policies and procedures for sheltering in place; -policy and procedures regarding use of volunteers; -methods for sharing information; -details regarding employee training and testing of the licensee's emergency plan On February 10, 2022, at approximately 3:38 p.m., LALD-A provided a policy to address a missing resident and a process for tracking residents. LALD-A also provided an emergency evacuation report that detailed devices and assistance each resident would need in event of an evacuation. LALD-A said the documents were	0 680		

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0 680	Continued From page 8 not included in the plan and acknowledged there were shortcomings with their current emergency plan. The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance policy, effective August 1, 2021, indicated it is the intent of the licensee to have in place an effective and compliant emergency preparedness plan, aligned with Appendix Z. The policy further indicated the plan would include all required elements of Appendix Z, be based on the community-based risk assessments and include four primary components: risk assessment and planning; policies and procedures; a communication plan and staff training and exercises/drills. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;	0 780		

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0 780	Continued From page 9 (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide proper working smoke alarm for resident room #250 as required by Minnesota Statutes, 144G.45, Subd. 2. This has 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 the potential to affect a large portion or all of the residents). The findings include: On February 11, 2022, between the hours of 10:30 a.m. to 1:30 p.m., survey staff toured the facility with the director of maintenance (DM)-M. At approximately 1:00 p.m. survey staff observed the smoke alarm in resident room #250 was covered in its entirety with a piece of plastic. The resident explained that his alarm sounds when using his toaster and/or coffee machine. The DM-M verified this finding during the toured.	0 780		

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0 780	Continued From page 10 On February 11, 2022, at approximately 1:00 p.m. and again at 2:15 p.m. at the exit interview, the DM-M acknowledged the above finding. No further information was provided. TIME PERIOD FOR CORRECTION: Three (3) day	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to maintain portable fire extinguishers in accordance with the State Fire Code as required by MN Statute 144G.45 Subd(a)(2). This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	0 790		

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0 790	Continued From page 11 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: On February 11, 2022, between the hours of 10:30 a.m. to 1:30 p.m., survey staff toured the facility with the director of maintenance (DM)-M. Survey staff observed portable fire extinguishers located throughout the facility including the main level, the kitchen, and the lower level were all tagged showing the required annual service date of 2/2021, but all lacked the records to show the required monthly visual inspections to date. At approximately 11:00 a.m. survey staff explained that the monthly visual inspection of each extinguisher was necessary to ensure all portable extinguishers are readily available, fully charged, and operable, at their designated location, and no obvious physical damage or condition to the extinguisher to prevent their operation when needed. If extinguishers were comprised or questionable, the licensee will need to get them to a vendor for servicing such as recharging or maintenance. The DM-M verified the findings during the tour. On February 11, 2022, at approximately 2:15 p.m., the DM-M acknowledged the above findings at the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800		

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0 800	Continued From page 12 (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents, visitors, and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 11, 2022, between the hours of 10:30 a.m. to 1:30 p.m., survey staff toured the facility with the director of maintenance (DM)-M. During the tour, the following findings were observed: PLUMBING -Water softener brine tank was not covered to protect the water treatment system from possible contamination. Survey staff also observed corrosion of the floor drain receptor, exterior surfaces of the building water service piping, and the concrete floor. Survey staff explained to the DM-M that the water softener system appeared to	0 800		

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0 800	Continued From page 13 be failing causing the brine tank to overflow, and if not resolved, the brine water overflows from the tank will create a very corrosive environment over time will cause failure of your builiding water supply system. The DM-M stated that service has been called and should be out in a day or so. -Plumbing traps of the plumbing fixtures were completely dried out in unoccupied resident rooms (102, 156, 160, 161, 203, and 212), as well as plumbing fixtures inside the bathrooms within the areas of the abandoned swimming pool. Survey staff explained to the DM-M that dried-out plumbing traps create unsafe and health risks to residents and employees over time by allowing sewer gas to enter the building environment. The DM-M stated that there will be a scheduled maintenance plan for routine replenishing of the traps on a regular basis. SMOKING ROOMS -The door to the 2nd-floor smoking room failed to latch when closed as required to maintain the fire-rated room. Furthermore, it was observed that the hardware of the same door was defected and had been taped over to prevent the door from closing properly. Survey staff explained to the DM-M, the door to the smoking room must be self-closing and latching at all times and a smoking policy must be adopted to ensure safe use of the smoking rooms. -The exhaust fans in the smoking rooms were not providing sufficient negative air movement to exhaust the air from the room when tested with a piece of paper. Furthermore, the exhaust fans were layered with thick dust. -The smoking room on the main floor lacked maintenance. Staff observed the floor and furnishings were dirty and dusty, and windows were foggy.	0 800		

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0 800	Continued From page 14 RESIDENT ROOM #250 -The bathroom exhaust fan in resident room #250 was not working when the switch was turned on. FIRE RATED DOORS -The rated doors to the elevator lobbies were wedged to keep doors opened. Further assessment, the magnetic door holder on the first elevator lobby failed to work properly when tested by the DM-M. -The set of fire (smoke partition) doors on the west side of the building failed to close properly. On February 11, 2022, at approximately 2:15 p.m., the DM-M, acknowledged the above findings at the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) 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) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.	0 810		

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0 810	Continued From page 15 (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on the observation, document review, and interview, the licensee failed to provide required content on the fire safety and evacuation plan, the minimum required training of staff on fire safety and evacuation plan, and minimum required number of evacuation drills. This has the potential to directly affect the safety of visitors, staff, and all residents receiving assisted living care. 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:	0 810		

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0 810	Continued From page 16 On February 11, 2022, at approximately 1:30 p.m., survey staff reviewed the facility fire safety and evacuation plan and related documentation. FIRE SAFETY AND EVACUATION PLAN -The documented plan lacked procedures for employee actions to be taken in the event of a fire or similar emergency for addressing resident movement, evacuation, and relocation, including unique resident-specific situations during an evacuation. Unique situations are residents who are wheelchair-bound, on walkers, bedridden, and needing assistance during an evacuation and must be addressed in the documentation. -The documentation lacked fire protection procedures for residents that can self assist in a fire or emergency. TRAINING - Lacked of the employee records to show required employee training on fire safety and evacuation plan for meeting the requirements upon hire and twice a year thereafter. DRILLS - The facility documented policy showed complying minimum numbers of required evacuation drills that must be performed by employees twice per year per shift, with at least one evacuation drill every other month, but record review showed insufficient evacuation drills performed to date by employees. The last recorded fire drill was August 25, 2021, at 10:00 a.m. Fire safety and evacuation drills must be performed in accordance with the facility's documented policy for compliance with Minnesota Statutes. Fire safety and evacuation drills may be performed at the same time if properly documented.	0 810		

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0 810	Continued From page 17 On February 11, 2022, at approximately 2:15 p.m., the Director of Maintenance-M acknowledged the above findings at the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 810		
01350 SS=E	144G.60 Subd. 5 Temporary staff When a facility contracts with a temporary staffing agency, those individuals must meet the same requirements required by this section for personnel employed by the facility and shall be treated as if they are staff of the facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure contracted staff utilized by the licensee met all orientation requirments as if employed by the facility for two of three unlicensed personnel ((ULP)-G, ULP-H) with employee records reviewed. In addidtion, the licensee failed to ensure contracted staff utilized by the licensee met all training and supervision requirments as if employed by the facility for three of three unlicensed personnel (ULP-G, ULP-H and ULP-F) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more	01350		

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01350	Continued From page 18 than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on February 10, 2022, at approximately 12:06 p.m., licensed assisted living director (LALD)-A confirmed the licensee utilized contracted staff to maintain staffing for the facility and later verified the licensee contracted employees from three different staffing agencies. Registered nurse (RN)-B stated the licensee used unlicensed staff to provide resident services such as dressing, making beds, toileting, in addition to delegated nursing tasks such as medication administration and treatments including compression stockings, ACE wraps, oxygen management, obtaining blood glucose levels and application of orthotic braces (prescribed medical device worn on the body to correct problems such as how one walks or stands). LACK OF EVIDENCE OF ORIENTATION TO ASSISTED LIVING ULP-G ULP-G was contracted on November 30, 2021, to provide direct care services to the licensee's residents. On February 7, 2022, at approximately 4:13 p.m., the surveyor observed ULP-G obtain a blood glucose from R1. ULP-H ULP-H was contracted on February 2, 2021, to provide direct care services to the licensee's residents.	01350		

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01350	Continued From page 19 On February 8, 2022, at approximately 7:06 a.m., the surveyor observed ULP-H obtain a blood glucose from R5. On February 8, 2022, at approximately 8:23 a.m., ULP-H stated she helped residents with tasks such as ADLs (activities of daily living), toileting, vital signs, COVID symptom screening, oxygen, blood glucose monitoring, application of TED hose (compression stockings), leg wraps, and medication administration including insulin. ULP-G's and ULP-H's employee files lacked evidence of having completed the following required content of orientation to assisted living: -overview of assisted living statutes; -introduction and review of the provider's policies and procedures related to the provision of AL services; -handling of emergencies and use of emergency services; -compliance with reporting of maltreatment of vulnerable adults; -assisted living bill of rights; -handling of resident complaints, reporting of complaints, and where to report; -consumer advocacy services; -principles of person-centered planning and service delivery; and -review of the types of assisted living services the employee will be providing and the facility's category of license. On February 10, 2022, at approximately 3:35 p.m., licensed assisted living director (LALD)-A verified there was no documentation in ULP-G or ULP-H's employee records to indicate they were oriented to assisted living.	01350		

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01350	Continued From page 20 LACK OF EVIDENCE OF SKILLS COMPETENCIES & SUPERVISION ULP-G ULP-G's employee file included a document titled Valley View Assisted Living Medication Administration Training. Listed on the document: -administration of medications (oral, topical, ear & eye drops, nebulizer & inhalant, insulin pens and liquids); -scheduled and PRN (as needed) mediations; -8 Rights of medications administration (resident, medication, dose, time, route, documentation, indication and follow up); -narcotic medication and count; -medication storage; -refills; -refusals; and -medication destruction. Also on the document was the statement "I have been trained in the above medication administration policy and procedures. I understand the training I have received." ULP-G and RN-C signed and dated the document November 30, 2021. ULP-G's record lacked evidence the RN trained ULP-G or determined competency for ULP-G to perform delegated tasks including: -compression stockings; -ACE wraps; -orthotics; and -oxygen use. Additionally, ULP-G's employee file lacked evidence the RN supervised ULP-G within 30 days of performing delegated tasks, as required. ULP-H ULP-H's employee file contained a certificate	01350		

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01350	Continued From page 21 titled Medication Pass Training, dated April 1, 2021, that indicated ULP-H completed training at the licensee's facility. The file also contained a similar certificate dated February 4, 2021, that indicated ULP-H completed medication pass training at a different facility, but not the licensees. Neither certificate identified what specific medication training was provided (such as routes of administration, medication rights, follow up on as-needed medications, handling of narcotic, etc.) or how the training was conducted (if it was classroom, computer-based or if it required demonstration by the participant.) ULP-H's record lacked evidence the RN trained ULP-H or determined competency for ULP-H to perform delegated tasks including: -compression stockings; -ACE wraps; -orthotics; and -oxygen use. Additionally, ULP-H's employee file lacked evidence the RN supervised ULP-H within 30 days of performing delegated tasks, as required. ULP-F ULP-F was contracted on February 3, 2022, to provide direct care services to the licensee's residents. On February 7, 2022, from approximately 4:00 p.m. to 4:30 p.m, the surveyor observed ULP-F provide direct care services and administer medications to residents on the 2nd floor west unit. ULP-F's employee file included a document titled Valley View Assisted Living Medication Administration Training. Listed on the document:	01350		

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01350	Continued From page 22 -administration of medications (oral, topical, ear & eye drops, nebulizer & inhalant, insulin pens and liquids); -scheduled and PRN (as needed) mediations; -8 Rights of medications administration (resident, medication, dose, time, route, documentation, indication and follow up); -narcotic medication and count; -medication storage; -refills; -refusals; and -medication destruction. Also on the document was the statement "I have been trained in the above medication administration policy and procedures. I understand the training I have received." ULP-F and RN-C signed and dated the document February 2, 2022. ULP-F's record lacked evidence ULP-F had been trained and/or determined competent by the registered nurse (RN) to perform delegated tasks including, compression stockings, ACE wraps, orthotics and oxygen use. On February 10, 2022, at approximately 12:47 p.m., regional director of nursing/compliance officer/registered nurse (RN)-N stated they did not do skills competency testing on staff used from contract agencies because those staff are CNAs (certified nursing assistants) and the licensee expects them to be competent. RN-N stated new staff from an agency come in one hour before the start of their scheduled shift, go right to the medication cart and receive medication training. RN-N stated the training included various routes of medication administration, insulin, blood sugars, handling of narcotics, and then the RN observes the staff doing the medication pass. RN-N could not say if	01350		

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they trained other skill areas this way, such as how to put on TED hose or manage oxygen, but stated she expected CNAs from a staffing agency to already be competent in those skills.

RN-N also stated the expectation was for unlicensed staff to be supervised within 30 days of starting on the floor and then at least annually. RN-N stated the RN should make random observations as well to ensure tasks are completed correctly and that additional observations and training would be made if staff had a medication error. RN-N could not say if RN supervisory observations had been completed at the site of the survey.

On February 10, 2022, at approximately 3:35 p.m., LALD-A confirmed there was no evidence the RN completed 30-day supervisions of unlicensed staff as required.

The licensee's 4.07 Temporary and Contracted Staff policy dated August 1, 2021, indicated temporary supplemental staffing or contracted staff would only be used if they met the same requirements required as hired employees and would be treated as if they were staff of the facility.

The licensee's 5.01 Orientation of Staff and Supervisors & Content policy dated August 1, 2021, indicated all staff of Valleyview of Owatonna providing and supervising direct care services must complete an orientation of Assisted Living facility licensing requirements and regulations before providing assisted living services to residents.

The licensee's 5.02 Competency Training Evaluations policy dated August 1, 2021,

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indicated when a RN of Valleyview of Owatonna delegates tasks, prior to the delegation of services the RN must make certain the ULP was trained in the proper methods to perform the tasks or procedures and able to demonstrate the ability to competently follow the procedures and perform the tasks. The policy also indicated a copy of all education, training and competency testing shall be kept in each employee's personnel file.

The licensee's 6.15 Staffing Requirements - Licensed Nurse and ULP policy, dated August 1, 2021, noted all staff persons of Valleyview Owatonna must be trained and competent in the provision of services consistent with current practice standards. Further, the policy indicated unlicensed personnel performing delegated nursing tasks in an assisted living facility must have successfully completed training and demonstrated competency by successfully completing a written or oral test of required topics and a practical skills test on required tasks and all the delegated tasks they will perform.

The licensee's 6.17 Supervision of Staff - Delegated Services policy, dated August 1, 2021, indicated staff who provide delegated nursing or therapy tasks to residents at Valleyview of Owatonna would be supervised by an RN. Further, the direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for Valleyview and first performs delegated tasks for residents.

The licensee's 7.15 Medication & Treatment - Administration & Delegation policy, dated August 1, 2021, indicated ordered medication and treatments may be administered by ULP who

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01350	Continued From page 25 have been delegated tasks by a RN. When a task is delegated to ULPs, the licensee ensures the RN has instructed the ULP in the proper methods with respect to each resident and the ULP has demonstrated their ability to competently follow the delegated medication administration or treatment/therapy to an RN. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01350		
01370 SS=D	144G.61 Subd. 2 Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders;	01370		

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01370	Continued From page 26 (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency was completed for one of three unlicensed personnel (ULP)-K to include all required content with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-K was hired November 9, 2021, to provide assisted living services to the licensee's residents.	01370		

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01370	Continued From page 27 On February 9, 2021, between approximately 8:15 a.m. and 9:10 a.m., the surveyor observed ULP-K provide direct care services, including medication administration to several residents on the first floor, west unit. ULP-K's employee file lacked documentation of training and competency evaluations for the following topics: - appropriate and safe techniques in personal hygiene and grooming, including: hair care and bathing, care of teeth, gums and oral prosthetic devices, care and use of hearing aids and dressing and assisting with toileting; and - standby assistance techniques and how to perform them. On February 10, 2022, at approximately 1:43 p.m., regional director of nursing/compliance officer/registered nurse (RN)-N acknowledged ULP-K's employee file did not have evidence the RN competency tested ULP-K in the required skill areas. RN-N stated RN-B (licensee's nursing director) completed the skills check with ULP-K but did not do the paperwork for the training record. The licensee's 5.02 Competency Training Evaluations policy dated August 1, 2021, indicated when a registered nurse (RN) of Valleyview of Owatonna delegates tasks, prior to the delegation of services the RN must make certain the ULP was trained in the proper methods to perform the tasks or procedures and able to demonstrate the ability to competently follow the procedures and perform the tasks. The policy indicated training and competency evaluations for all ULPs will include, among other skills, the following:	01370		

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01370	Continued From page 28 - appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums and oral prosthetic devices; (iii) care and use of hearing aides; and (iv) dressing and assisting with toileting. - standby assistance techniques and how to perform them. The policy also indicated a copy of all education, training and competency testing shall be kept in each employee's personnel file. The licensee's 6.15 Staffing Requirements - Licensed Nurse and ULP policy, dated August 1, 2021, noted all staff persons of Valleyview Owatonna must be trained and competent in the provision of services consistent with current practice standards. Further, the policy indicated unlicensed personnel performing delegated nursing tasks in an assisted living facility must have successfully completed training and demonstrated competency by successfully completing a written or oral test of required topics and a practical skills test on required tasks and all the delegated tasks they will perform. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting	01380		

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01380	Continued From page 29 resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency was completed for one of three unlicensed personnel (ULP)-K to include all required content with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-K was hired November 9, 2021, to provide assisted living services to the licensee's residents. On February 9, 2021, between approximately 8:15 a.m. and 9:10 a.m., the surveyor observed	01380		

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01380	Continued From page 30 ULP-K provide direct care services, including medication administration to several residents on the first floor, west unit. ULP-K's employee file lacked documentation of training and competency evaluations for the following topics: - reading and recording temperature, pulse and respirations of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning; - other RN/professionally delegated tasks. On February 10, 2022, at approximately 1:43 p.m., regional director of nursing/compliance officer/registered nurse (RN)-N acknowledged ULP-K's employee file did not have evidence the RN competency tested ULP-K in the required skill areas. RN-N stated RN-B (licensee's nursing director) completed the skills check with ULP-K but did not do the paperwork for the training record. The licensee's 5.02 Competency Training Evaluations policy dated August 1, 2021, indicated when a registered nurse (RN) of Valleyview of Owatonna delegates tasks, prior to the delegation of services the RN must make certain the ULP was trained in the proper methods to perform the tasks or procedures and able to demonstrate the ability to competently follow the procedures and perform the tasks. The policy indicated training and competency evaluations for all ULPs will include, among other skills, the following: - reading and recording temperature, pulse and respirations of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning; and - administering mediations or treatments as	01380		

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01380	Continued From page 31 required. The policy also indicated a copy of all education, training and competency testing shall be kept in each employee's personnel file. The licensee's 6.15 Staffing Requirements - Licensed Nurse and ULP policy, dated August 1, 2021, noted all staff persons of Valleyview Owatonna must be trained and competent in the provision of services consistent with current practice standards. Further, the policy indicated unlicensed personnel performing delegated nursing tasks in an assisted living facility must have successfully completed training and demonstrated competency by successfully completing a written or oral test of required topics and a practical skills test on required tasks and all the delegated tasks they will perform. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional	01440		

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01440	Continued From page 32 and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date of which the individual began working for the licensee for one of two unlicensed personnel (ULP)-K with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-K was hired November 9, 2021, to provide direct care services to licensee's residents at the assisted living. ULP-K's employee record lacked documentation of a registered nurse (RN) supervising ULP-K performing delegated tasks within 30 days of beginning work with the	01440		

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01440	Continued From page 33 licensee. On February 9, 2022, between approximately 8:15 a.m. and 9:10 a.m., the surveyor observed ULP-K provide direct care services, including medication administration to several residents on the first floor, west unit. During an interview on February 8, 2022, at about 9:56 a.m., ULP-K confirmed she had not received a supervisory visit by the RN of her performing medication administration or any other tasks. ULP-K stated she routinely did medication administration, including insulin, eye drops and narcotics. On February 10, 2022, at approximately 12:47 p.m., Regional director of nursing/registered nurse (RN-N) stated the expectation was for unlicensed staff to be supervised within 30 days of starting on the floor and then at least annually. RN-N stated the RN should make random observations as well to ensure tasks are completed correctly and that additional observations and training would be made if staff had a medication error. RN-N could not say if RN supervisory observations had been completed at the site of the survey. On February 10, 2022, at approximately 3:35 p.m., LALD-A confirmed there was no evidence 30-day supervisions of unlicensed staff were completed by the RN as required. The licensee's 6.17 Supervision of Staff - Delegated Services policy, dated August 1, 2021, indicated direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual began work and first performed the	01440		

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01440	Continued From page 34 delegated tasks for residents. The policy also indicated documentation of supervision activities would be retained in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01440		
01760 SS=E	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 observation, interview and record review, the licensee failed to ensure an insulin pen was primed prior to setting the dose for one of three residents (R1) who received insulin. In addition, the licensee failed to ensure medication was administered as ordered for one of two residents who had inhalers (R2) observed during medication pass with records reviewed. This practice resulted in a level two violation (a	01760		

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violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

INSULIN PEN NOT PRIMED PRIOR TO ADMINISTRATION

R1's diagnoses included diabetes with diabetic neuropathy.

R1's service plan, dated August 1, 2021, indicated R1 received medication administration four times daily, to be provided by the resident assistant/home health aide (unlicensed personnel).

R1's prescriber's orders for insulin dated January 20, 2022, directed to inject 18 units Novolog (brand name of insulin) subcutaneous three times daily with meals.

On February 7, 2022, at approximately 4:13 p.m., the surveyor observed unlicensed personnel (ULP)-G obtain a blood sugar from R1 and then prepare to administer R1's insulin. R1's insulin was dispensed in a Novolog (brand name) Flex Pen, and ULP-G dialed up 18 units, which was verified by the surveyor. ULP-G did not prime R1's insulin pen prior to dialing up the prescribed dose. ULP-G then administered R1's insulin.

At 4:16 p.m., ULP-G acknowledged and stated "I

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forgot" to prime the insulin pen. ULP-G stated she normally makes sure it (insulin) comes out and that it should be primed with two units prior to administration, and that is how she was taught.

The employee record indicated ULP-G had computer-based training, completed November 30, 2021, on both insulin administration and insulin pens. ULP-G's record lacked evidence of having demonstrated competency to a registered nurse (RN) on the use of an insulin pen.

On February 8, 2022, at approximately 2:18 p.m., RN-C stated prior to administration, the insulin pens need to be primed, and that was part of the skill competency for administering insulin. RN-C stated ULP-G would need some re-education.

A facility document "Demonstrative Skill Assessment - Insulin Pens, dated 2007, listed the procedure for skills competency for the use of insulin pen. #8 directed to "prime the pen and then dial up the correct dose."

Novolog Insulin FlexPen manufacturer's guide, dated April 2021, directed to prime the pen with 2 Units and make sure a drop appears, prior to each use before selecting a dose.

INHALED MEDICATION NOT GIVEN AS ORDERED

R2's diagnoses included hypertension, chronic obstructive pulmonary disease (COPD) and diabetes.

R2's service plan dated September 8, 2021, and medication management plan, revised December 20, 2021, indicated R2 received medication administered by unlicensed personnel seven

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times daily. R2's prescriber's orders included two inhaled medications: Advair Diskus (brand name) of fluticisone/salmeterol 250/5 Aerosol (combination of two medicines that are used to help with symptoms of asthma and breathing) and directed one puff by mouth twice daily-rinse mouth after use; and Spiriva Aerosol 1.25 mcg (micrograms), inhale 2 puffs once daily (medicine to treat bronchospasm associated with COPD).

On February 8, 2022, at approximately 8:25 a.m., the surveyor observed unlicensed personnel (ULP)-L remove the two inhaled medicines out of the medication cart and hand them to R2. ULP-L first gave R2 the Spiriva container, and R2 held the tube opening in his mouth, then pressed and inhaled two separate puffs. Next, ULP-L gave R2 the Advair medication and R2 inhaled one puff. ULP-L did not have R2 rinse his mouth following the administration of the Advair medication as ordered. ULP-L continued with the tasks of obtaining R1's blood sugar. At the conclusion of R2's medication pass, ULP-L returned the medications to the cart where she disposed of the used supplies, removed gloves and documented the administration.

At approximately 8:33 a.m., ULP-L verified she did not have R2 rinse his mouth following the administration of the Advair. R2 verified those instructions were included on the pharmacy label and in the medication administration record. ULP-L stated, "I did not do that."

On February 9, 2022, at approximately 2:25 p.m., RN-C stated typically following steroid inhalation rinsing the mouth and gargling would help prevent the mouth from getting sore. RN-C stated she would follow-up with additional training.

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01760	Continued From page 38 On February 9, 2022, at approximately 4:07 p.m., RN-B stated the specific instructions should be followed as they are written on the medication administration record and medications were to be given as ordered. A policy regarding administration of medication as prescribed was not available. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and	01790		

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01790	Continued From page 39 (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse	01790		

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01790	Continued From page 40 (RN) developed a written procedure for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse or pharmacist was not available. This had the potential to affect all fifty-nine (59) current residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 February 7, 2022, at approximately 10:30 a.m., interim licensed assisted living director (LALD)-A and registered nurse (RN)-B confirmed all 59 residents who resided at the facility received medication management services. The licensee failed to develop and implement a written procedure for the ULP providing medications for residents having unplanned times away. The licensee's Medication Management - Planned and Unplanned Time Away policy, dated August 1, 2021, indicated for unplanned resident time away when a pharmacist or licensed nurse was not available, the RN may delegate this task to ULP if the RN has developed written procedures for the ULP, including any special instructions or procedures regarding controlled substances that are prescribed for the resident.	01790		

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01790	Continued From page 41 The licensee's policy directed the RN to develop written procedures for the unlicensed personnel. The licensee lacked written procedure to include: - the type of container or containers to be used for the medication appropriate to the provider's medication system; - how the container or containers must be labeled; - written information about the medications to be provided; - how the ULP must document in the resident's record that medications have been provided, including documenting the date the medications where provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; - how the RN would be notified that medications have been provided and whether the RN needs to be contacted before the medications are given to the resident or the designated representative; - a review by the RN of the completion of this task to verify that this task was completed accurately by the ULP; and - how the ULP must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each medication returned. On February 10, 2022, at approximately 1:47 p.m., RN-N said the licensee did have a training for staff to label envelopes with medications but stated, "we need to be more specific." RN-N acknowledged the lack of a written procedure for staff to follow to prepare medications for unplanned resident time away from the facility. RN-N stated preparing medications for residents with unplanned leaves happened frequently.	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25302	A. BUILDING: _____ B. WING _____	02/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01790	Continued From page 42 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
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 by: Based on observation and interview, the licensee failed to ensure outdated and refused medications were securely stored prior to destruction in 2 of 2 medication rooms reviewed. 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: On February 9, 2022, at approximately 8:22 a.m., the surveyor observed the door to the 1st floor medication room open; staff were seated at the desks. On top of the desk was an opened and outdated resident prescription of eye drops. To the right of the desktop was a file holder attached	01880		

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	25302	A. BUILDING: _____ B. WING _____	02/11/2022

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01880	Continued From page 43 to the wall which held a number of small envelopes, each labeled with a resident name and contents the surveyor noted to be medications. Also observed was a blister pack of medications, label removed, with two unopened/unpunched pills in the package. ULP-H stated the little packages and other meds were either refused or outdated resident medications, and those envelopes were stored there until the nurse destroyed them. ULP-H stated it was an "unsafe" practice. During observation on February 10, 2022, at approximately 9:10 a.m., the surveyor observed the door to the 2nd floor medication room opened. ULP-L stood at a medication cart directly outside the door; no one was in the medication room. In a small plastic container atop a shelf in the medication room were: a blister pack with seven remaining pills; five small envelopes, each labeled with resident name, room number, med time and the name of medication with dosage; and a box of nasal spray medication. ULP-L said the medication room door was usually shut, unless someone was right outside the door. ULP-L also verified the presence of the medications in envelopes and contents of the plastic container. At approximately 9:16 a.m., registered nurse (RN)-B verified the medications in small envelopes, bottles and blister packs contained in the small plastic box in the 2nd floor medication room. RN-B said he was not aware of the medications similarly stored on the first floor medication room. RN-B stated the medications were awaiting destruction and should not have been left out. RN-B stated the medications should have been stored in the locked medication cart until they could be moved to the locked disposal	01880		

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01880	Continued From page 44 room on 2nd floor. The licensee's 7.23 Medication Disposal policy dated August 1, 2021, indicated staff of Valleyview Owatonna would dispose any mediation, as needed, in a proper way. The policy indicated the licensee used Stericycle system to dispose of medications, which was kept locked up in a medications room until medication is disposed of by Nurse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
02310 SS=G	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for two of two residents (R3 and R5) who utilized bed rails with records reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a	02310	On February 9, 2022 the immediacy of correction order 2310 was removed, however non-compliance remains at a scope and level of G.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25302	A. BUILDING: _____ B. WING _____	02/11/2022

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02310	Continued From page 45 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: R3 R3's diagnoses included, but were not limited to, cerebral palsy. On February 8, 2022, at approximately 7:50 a.m., the surveyor observed a kind of rail on the side of R3's bed. The device was shaped like a large number "9", and was attached to a wood board that was about 15" wide and 24" long. The board was positioned between the mattress and the box spring, which helped support the rail device. At approximately 7:52 a.m., unlicensed personnel (ULP)- H assisted R3 with morning cares, and asked R3, who was lying in bed, to help himself to a seated position at the side of the bed. While sitting up and with ULP-H's assistance, R3 briefly grasped the side rail with his left hand. R3 then grasped the handles of the resident's wheelchair, parked directly in front of R3 and ULP-H completed cares. At approximately 8:01 a.m., ULP-H stated R3 used the rail when he attempted to get up, stating R3 did that independently, even though he was not supposed to. ULP-H stated R3 used the rail to maintain balance when he pulled himself up off the bed. On February 8, 2022, at approximately 9:59 a.m., R3 told the surveyor he uses the rail for balance, "When I'm getting out of bed", and that R3 has had the rail for a long time. R3's record lacked any information regarding the	02310		

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02310	Continued From page 46 bed rail use, including assessment or indication R3 had previously used bed rails. R3's record lacked documentation the registered nurse (RN) discussed the appropriateness of the bed rail, determination if the rail was safe for R3 to use, and the risks versus benefits of the bed rail. R5 R5's diagnoses included but were not limited to depression. On February 8, 2022, at approximately 10:47 a.m., R5 was observed seated in a recliner in the resident room. Attached to the exit side of the bed, closest to the room door was an upside down-shaped bed rail, about 2' (feet) wide and 3' tall, with a second upside down, 'U' shaped rail positioned below the larger rail. The left side of the rail shared a vertical bar. The rail was attached to two horizontal bars that were located between the mattress and box spring, and were secured tightly to the frame with a strap at the opposite side of the bed. On February 8, 2022, at approximately 10:47 a.m., R5 stated he uses the rail all the time and that he can't get out of bed without it. R5's record lacked any information regarding the bed rail use including assessment or indication R5 had previously used bed rails. R5's record lacked documentation the RN discussed the appropriateness of the bed rail, determination if the rail was safe for R5 to use, and the risks versus benefits of the bed rail. On February 8, 2022, at approximately 3:59 p.m., licensed assisted living director (LALD)-B stated it does not appear there is documentation in place	02310		

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02310	Continued From page 47 including assessments of the side rails and explanation of risks and benefits for R3 and R5. Further, LALD-A stated it would be her assumption no resident with rails would have this documentation and said there were about six resident with rails. LALD-A stated they are taking immediate action to correct this and are putting together a list of those resident with rails with no documentation. LALD-A provided a policy, and stated, "We'll get started on this and get this squared away to where it needs to be". The licensee's 6.28 Side Rails policy, dated August 1, 2021, indicated when the licensee is aware a resident is utilizing side rails (a medical device) on a bed, the licensee will assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is safe design and utilized consistent the with manufacturer's directions. The procedure directed that education provided will be documented in the resident record. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	02310		

Minnesota Department of Health
Division of Envrionmental Health, FPLS
PO BOX 64975
St Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *02/09/22*
Time: 13:15:00
Report: 8040221002

Food and Beverage Establishment Inspection Report

Location:
Valleyview Assisted Living
1212 West Frontage Road
Owatonna, MN55060
Steele County, 74

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

License Categories:

Expires on: / /

Operator:

Phone #: 5074463522
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.14B

MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.

WIPING CLOTH SANITIZER BUCKET MEASURED AT 0PPM OF QUATERNARY AMMONIUM. DISPENSER AT 3 COMP SINK HAS AN AIR BUBBLE IN THE LINE, NOT PROPERLY DISPENSING PRODUCT. TERESA REMOVED DISPENSING LINE AND MIXED SANITIZER BUCKET MANUALLY TO PROVIDE 200 PPM.

Corrected on Site

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

OBSERVED TWO CROCKPOTS STORED UNDER THE JUICE MACHINE. REMOVE CROCKPOTS FROM PREMISES.

Comply By: 02/17/22

6-200 Physical Facility Design and Construction

6-201.11A

MN Rule 4626.1335A Design, construct, and install floors, floor coverings, walls, wall coverings, and ceilings to be smooth and easily cleanable.

INSTALL MISSING CEILING TILES, REPLACE BROKEN CEILING TILES AND REPLACE STAINED CEILING TILES.

Comply By: 08/10/22

6-200 Physical Facility Design and Construction

6-201.13A

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

BROKEN COVE BEHIND ICE MACHINE, MISSING COVE BASE UNDER PREP SINK AREA. PROVIDE INTEGRAL COVED BASE.

Comply By: 08/10/22

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

REPAIR DAMAGED AND BROKEN CEILING TILES AND WALL TILES NEAR ICE MACHINE.

Comply By: 08/10/22

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

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

CLEAN MOLD BUILD-UP ON FLOOR TILES AROUND ICE MACHINE.

Comply By: 02/17/22

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: RAG BUCKET
Violation Issued: No

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

Food and Equipment Temperatures

Process/Item: Cooking
Temperature: 36-164 Degrees Fahrenheit - Location: GROUND BEEF
Violation Issued: No

Process/Item: Server Station
Temperature: 41 Degrees Fahrenheit - Location: CHOCOLATE MILK DISPENSER
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 43 Degrees Fahrenheit - Location: SLICED TOMATO
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 38 Degrees Fahrenheit - Location: EGG SALAD
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Walk-In Cooler
Temperature: 39 Degrees Fahrenheit - Location: SLICED TURKEY
Violation Issued: No

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

INSPECTION CONDUCTED AS PART OF HRD SURVEY. BRUCE MELCHERT, HRD NURSING EVALUATOR PRESENT DURING INSPECTION.

TERESA BUSSE, COOK (M) PRESENT. DISCUSSED EMPLOYEE ILLNESS LOG, ILLNESS SCREENING POLICY, VOMIT / FECAL CLEAN-UP PROCEDURES, COOLING AND USE OF RAW SHELL EGGS.

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 8040221002 of 02/09/22.

Certified Food Protection Manager: SHEILA BROWN

Certification Number: FM5524 Expires: 05/18/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
TERESA BUSSE
COOK (M)

Signed: _____
Matthew Finkenbiner
Sanitarian Supervisor
Rochester District Office
507-206-2744
matthew.finkenbiner@state.mn.us