Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL308353608M
Compliance #: HL308353190C

Date Concluded: October 28, 2026

Name, Address, and County of Licensee Investigated:
Valleyview of Jordan
4061 West 173rd Street
Jordan, MN 55352
Scott County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Maerin Renee, RN, Special Investigator

Finding: Not Substantiated

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

Initial Investigation Allegation(s):
The facility neglected the resident when mental health medications were not refilled in a timely manner. The medications were clonazepam (for anxiety), lamotrigine (for mood stabilization), and melatonin (for insomnia). The resident required hospitalization due to missing her medications.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident received mental health medication as prescribed. When the resident experienced a mental health decline, the resident was sent to the hospital for further evaluation.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted case management. The investigation included review of the resident record, hospital records, pharmacy records, facility incident reports, personnel files, staff schedules, and related facility policy and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included paranoid schizophrenia, depression, anxiety, and insomnia. The resident's services included assistance with behavioral management and medication management. The resident's assessment indicated the resident was oriented to person, place, time, and situation but occasionally made poor decisions and lacked insight into her mental health diagnoses.

The resident reported to nursing staff that her mental health was declining. The resident denied suicidal ideation but requested to go to the hospital. Facility staff transferred the resident to the hospital for further evaluation. The resident stayed overnight at the hospital and returned the following day.

Hospital records indicated the resident was evaluated for a mental health issue, specifically acute paranoia, with a history of paranoia, insomnia, depression, and paranoid schizophrenia. The resident stated she felt like people at her facility did not like her and wanted to hurt her and reported the symptoms had been ongoing for two weeks and worsened that day. The resident stayed overnight at the hospital and discharged back to the facility the following day.

Review of the resident's medical record indicated the resident received mental health medication as prescribed.

When interviewed, a nurse said the resident made her own appointments with various providers so it could be hard to keep track of who she saw and when. There were times the facility needed to wait for refills from providers because the resident would miss her appointments and the providers would not prescribe refills until they saw her. The nurse said upon review of the resident's MARs, she did not see gaps in the resident's medications during the timeframe in question and when the resident reported concerns with her mental health the resident was sent for further mental health evaluation.

When interviewed, the resident stated the facility corrected her medications right away. Although she went to the hospital, the resident said it had nothing to do with her medications. The resident reported everything was "great," and described the staff as good people who did a great job.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

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

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

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: N/A, the resident is her own decision-maker.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility reviewed the resident’s medication regimen and worked closely with the resident and providers to manage her medications and sent the resident to the hospital when she reported mental health symptoms.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30835	A. BUILDING: _____ B. WING _____	C 08/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEYVIEW OF JORDAN LLC	4061 WEST 173RD STREET JORDAN, MN 55352

(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 On August 25, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL308353190C/#HL308353608M. No correction orders are issued.	0 000		