DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 02T1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00750

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245423**
2.STATE VENDOR OR MEDICAID NO.
(L2) **925340800**

3. NAME AND ADDRESS OF FACILITY
(L3) **CHOSEN VALLEY CARE CENTER**
(L4) **1102 LIBERTY STREET SOUTHEAST**
(L5) **CHATFIELD, MN** (L6) **55923**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/05/2015** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **78** (L18)

13.Total Certified Beds **78** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	78			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Michele McFarland, HFE NE II 11/16/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 11/16/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

CMS Certification Number (CCN): 245423

November 16, 2015

Mr. Craig Backen, Administrator
Chosen Valley Care Center
1102 Liberty Street Southeast
Chatfield, MN 55923

Dear Mr. Backen:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective October 19, 2015 the above facility is certified for:

78 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 78 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
November 16, 2015

Mr. Craig Backen, Administrator
Chosen Valley Care Center
1102 Liberty Street Southeast
Chatfield, MN 55923

RE: Project Number S5423025

Dear Mr. Backen:

On September 22, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 10, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On November 5, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on November 13, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 10, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 19, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 10, 2015, effective October 19, 2015 and therefore remedies outlined in our letter to you dated September 22, 2015, will not be imposed.

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245423	A. Building B. Wing	11/5/2015

Name of Facility	Street Address, City, State, Zip Code
CHOSEN VALLEY CARE CENTER	1102 LIBERTY STREET SOUTHEAST CHATFIELD, MN 55923

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**10/19/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	**10/19/2015**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	**10/19/2015**
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By GPN/kfd	Date: 11/16/2015	Signature of Surveyor: 31217	Date: 11/05/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 9/10/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245423	CHOSEN VALLEY CARE CENTER

Type of Survey (select all that apply):

D	H				

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

A					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. Team Leader 27200	11/13/15	11/13/15	0.25	0.00	0.00	0.00	0.00	0.25
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

	0.25
Total Supervisory Review Hours	0.00
Total Clerical/Data Entry Hours.....	0.25

Was Statement of Deficiencies given to the provider on-site at completion of the survey? .....

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 02T1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00750

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245423**
2.STATE VENDOR OR MEDICAID NO.
(L2) **925340800**

3. NAME AND ADDRESS OF FACILITY
(L3) **CHOSEN VALLEY CARE CENTER**
(L4) **1102 LIBERTY STREET SOUTHEAST**
(L5) **CHATFIELD, MN** (L6) **55923**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/10/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **78** (L18)

13.Total Certified Beds **78** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	78			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Austin Fry, HFE NE II 10/01/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/20/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 22, 2015

Mr. Craig Backen, Administrator
Chosen Valley Care Center
1102 Liberty Street Southeast
Chatfield, Minnesota 55923

RE: Project Number S5423025

Dear Mr. Backen:

On September 10, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 20, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A

Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by December 10, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 10, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Gary Schroeder, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
gary.schroeder@state.mn.us
Telephone: (507) 361-6204

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING _____ B. WING _____	09/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOSEN VALLEY CARE CENTER	1102 LIBERTY STREET SOUTHEAST CHATFIELD, MN 55923

(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) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff followed the plan of care for repositioning every hour as assessed need and use device to aide in wheel chair to prevent leaning for 1 of 3 residents (R4) reviewed for pressure ulcers and proper positioning. Findings include: R4's care plan dated 4/23/15, identified R4 was "at risk for impaired skin integrity" and included an intervention of "Turning & repositioning	F 282	This plan and response to CMS-2567 regarding Tag F 282, is written solely to maintain certification in the Medicare and Medical Assistance programs. We wish to preserve our right to dispute these findings in their entirely should any remedies be imposed. The policies and procedures for repositioning has been reviewed and revised. The Policies and procedure for care planning have been reviewed and found appropriate.	10/19/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/01/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING _____ B. WING _____	09/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOSEN VALLEY CARE CENTER	1102 LIBERTY STREET SOUTHEAST CHATFIELD, MN 55923

(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) COMPLETION DATE
F 282	Continued From page 1 Program: T/R [turn and reposition] q [every] 1 hour when in bed or chair..." During observation on 9/10/15, at 7:03 a.m. R4 was in her wheelchair in the commons area watching television. At 8:14 a.m. (one hour and 11 minutes later), nursing assistant (NA)-A and NA-B wheeled R4 to her room, and then assisted her back to the commons area a couple minutes later. However, they had not fully repositioned R4 to remove pressure to bottom. During continued continuous observation of R4 on 9/10/15, at 9:08 a.m. (two hours and five minutes later form start of observation at 7:03 a.m.) R4 was again assisted to her room by NA-B and another unidentified staff member. R4 was assisted with a mechanical lift to lay in bed, and licensed practical nurse (LPN)-A changed a dressing to an identified open area on R4's coccyx which LPN-A described as, "A couple centimeters in length." During an interview on 9/10/15, at 11:05 a.m. the director of nursing (DON) stated R4 should be repositioned every hour according to R4's care plan. LACK OF CARE PLAN INTERVENTION DEVICE TO SUPPORT HEAD AND SHOULDERS: R4's care plan dated 4/23/15, identified R4 had "impaired mobility" and demonstrated a "lack of voluntary movement ...poor balance & poor trunk control..." Further, the care plan directed staff to, "Cue me to maintain position in broda [sic] chair...", "...have a neck bolster attached to the headrest on my broda [sic] chair as a way of holding my head in a more midline position," and,	F 282	After it was known that resident (R4) was not being repositioned according to care plan and fully offloaded from pressure points, the nursing assistants were educated on repositioning and offloading. After an observation of resident (R4) wheelchair positioning was shared with the RN Case Manager. Physician was contacted and made aware. Resident¿s (R4) physician then gave an order for Occupational Therapy to evaluate and treat for wheelchair positioning. Resident¿s neck bolster was located and is being used according to occupational therapists recommendations and resident (R4) care plan. All residents who residents who reside at Chosen Valley Care Center have the potential to be affected by this deficient practice. Nursing Assistants, Nurses and TMAs have initially been notified in shift report of expectations of repositioning residents according to care plan, defining what offloading means in regards to repositioning and expectations of wheelchair positioning and use of positioning devices according to care plans starting on 9/24/15. All licensed and unlicensed staff will be re-educated on resident repositioning on October 14th, 15th and 16th 2015. A Wheelchair Positioning Monitor was developed and will be completed to ensure that residents are correctly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING _____ B. WING _____	09/10/2015

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F 282	Continued From page 2 "Please take great care when position me in my chair ...that it does not promote left lateral leaning." R4's quarterly Minimum Data Set (MDS) dated 6/21/15, indicated she was moderately cognitively impaired and required extensive assist with a mechanical lift for transfers and repositioning. During observation on 9/8/15, at 7:18 p.m. R4 was seated in her Broda chair leaning far over to her left side with her neck tilted causing her ear to nearly touch her shoulder. R4 had a black lateral support device in the chair, however she remained leaning significantly to her left side even with its use. Further, R4 did not have any neck bolster in place as directed by the plan of care. During subsequent observations of R4 on 9/9/15, at 3:03 p.m., and 9/10/15 at 7:57 a.m., R4 continued to be in her Broda chair leaning significantly to her left side and without any neck bolstering device present. During interview on 9/10/15, at 11:30 a.m. registered nurse (RN)-A stated she reviewed R4's care plan and R4 should be using a neck bolster to help support her positioning, but RN-A added she was unaware what the device looked like or when it was actually being used, "I'm not really sure what it is." Further, RN-A stated she would "expect staff to do something about [R4's] head alignment." A facility policy on care planning was requested, but none was provided.	F 282	positioned in wheelchair and positioning devices are used according to residents care plan. A Repositioning Monitor was developed and will be completed to ensure that residents are repositioned according to care plan to promote wound healing and prevention of pressure ulcers. The Director of Nursing or designee will complete these monitors once weekly for four weeks and then quarterly monitors will be completed and presented at the quality assurance meeting for one full year.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		10/19/15

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F 309	Continued From page 3 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper wheel chair positioning for 1 of 2 residents (R4) reviewed for wheel chair positioning. Findings include: R4's quarterly Minimum Data Set (MDS) dated 6/21/15, indicated she was moderately cognitively impaired and required extensive assist with a mechanical lift for transfers and repositioning. R4's care plan dated 4/23/15, identified R4 had "impaired mobility" and demonstrated a "lack of voluntary movement ...poor balance & [and] poor trunk control..." Further, the care plan directed staff to, "Cue me to maintain position in broda [sic] chair...", "...have a neck bolster attached to the headrest on my broda [sic] chair as a way of holding my head in a more midline position," and, "Please take great care when position me in my chair ...that it does not promote left lateral leaning." During observation on 9/8/15, at 7:18 p.m. R4 was seated in her Broda chair leaning far over to her left side with her neck tilted causing her ear to nearly touch her shoulder. R4 had a black lateral	F 309	This plan and response to CMS-2567 regarding Tag F 309, is written solely to maintain certification in the Medicare and Medical Assistance programs. We wish to preserve our right to dispute these findings in their entirely should any remedies be imposed. The policies and procedures for wheelchair positioning has been reviewed and revised. After an observation of resident (R4) wheelchair positioning was shared with case manager. Physician was contacted and made aware. Resident¿s (R4) physician then gave an order for Occupational Therapy to evaluate and treat for wheelchair positioning. Resident¿s neck bolster was located and is being used according to the occupational therapists recommendations and resident (R4) care plan. All residents who residents who reside at Chosen Valley Care Center have the potential to be affected by this deficient practice.	

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F 309	Continued From page 4 support device in the chair, however she remained leaning significantly to her left side even with its use. Further, R4 did not have any neck bolster in place as directed by the plan of care. During subsequent observations of R4 on 9/9/15, at 3:03 p.m., and 9/10/15 at 7:57 a.m., R4 continued to be in her Broda chair leaning significantly to her left side and without any neck bolstering device present. During interview on 9/10/15, at 10:27 a.m. certified occupational therapy assistant (COTA)-C stated she was not familiar with R4 or her wheel chair positioning needs. R4 had not been on her caseload or referred to occupational therapy since 9/24/14. During interview on 9/10/15, at 11:30 a.m. registered nurse (RN)-A stated she reviewed R4's care plan and R4 should be using a neck bolster to help support her positioning, but RN-A added she was unaware what the device looked like or when it was actually being used, "I'm not really sure what it is." RN-A stated she would "expect staff to do something about [R4]'s head alignment." Further, RN-A stated R4's positioning should be addressed, "We should have done something with it." A facility policy on wheelchair positioning was requested, but none was provided.	F 309	Nursing Assistants, Nurses and TMAs have initially been notified in shift report of expectations of wheelchair positioning and use of positioning devices according to care plans starting on 9/24/15. All licensed and unlicensed staff will be re-educated on resident wheelchair positioning on October 14th, 15th and 16th 2015. A Wheelchair Positioning Monitor was developed and will be completed to ensure that residents are correctly positioned in wheelchair and positioning devices are used according to residents care plan. The Director of Nursing or designee will complete this monitor once weekly for four weeks and then quarterly monitors will be completed and presented at the quality assurance meeting for one full year	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the	F 314		10/19/15

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F 314	Continued From page 5 individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure timely repositioning to promote healing and reduce the risk of further pressure ulcer development for 1 of 3 residents (R4) reviewed for pressure ulcers. Findings include: R4's quarterly Minimum Data Set (MDS) dated 6/21/15, identified R4 had moderate cognitive impairment, was totally dependent on staff for transfers, and was at risk for pressure ulcer development, but had no current pressure ulcers. During observation on 9/10/15, at 7:03 a.m. R4 was in her wheelchair in the commons area watching television. At 8:14 a.m. (one hour and 11 minutes later), nursing assistant (NA)-A and NA-B wheeled R4 to her room, and then assisted her back to the commons area a couple minutes later. When interviewed on 9/10/15, at 8:17 a.m. NA-A stated her and NA-B had just repositioned R4, however added they did not off load (to fully remove pressure to the bony prominences to increase circulation to skin area to prevent skin breakdown) her weight from the wheelchair, but rather just "moved her from side to side." Further, NA-A stated staff do this for R4 "every	F 314	This plan and response to CMS-2567 regarding Tag F 314, is written solely to maintain certification in the Medicare and Medical Assistance programs. We wish to preserve our right to dispute these findings in their entirely should any remedies be imposed. The policies and procedures for repositioning have been reviewed and revised. After it was known that resident (R4) was not being repositioned according to care plan and fully offloaded from pressure points, the nursing assistants were educated on repositioning and offloading. All residents who residents who reside at Chosen Valley Care Center have the potential to be affected by this deficient practice. Nursing Assistants, Nurses and TMAs have initially been notified in shift report of expectations of repositioning residents according to care plan and defining what offloading means in regards to repositioning starting on 9/24/15. All licensed and unlicensed staff will be	

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F 314	Continued From page 6 hour or so." During continued continuous observation of R4 on 9/10/15, at 9:08 a.m. (two hours and five minutes later from 7:03 a.m.) R4 was again assisted to her room by NA-B and another unidentified staff member. R4 was assisted with a mechanical lift to lay in bed, and licensed practical nurse (LPN)-A removed an old duoderm dressing (an opaque dressing for wounds) from her coccyx. R4 had an open area on the upper portion of her coccyx which appeared red and approximately 1 X 0.5 centimeters in size. LPN-A cleansed the site, and applied a new duoderm dressing to R4's coccyx. LPN-A described the open area as, "A couple centimeters in length." R4's care plan dated 4/23/15, identified R4 was "at risk for impaired skin integrity", and included an intervention of, "Turning & repositioning Program: T/R [turn and reposition] q [every] 1 hour when in bed or chair..." R4's progress notes dated 9/1/15, identified, "RN [registered nurse] assessment of coccyx split ... measures 0.5 x [by] 0.5 cm [centimeters] and is superficial ..." Further, the note identified interventions to promote healing and reduce R4's risk of further pressure ulcer formation which included, "T&R [turn and reposition] every 2 hours is not appropriate and will change to every 1 hour to promote wound healing ..." A subsequent progress note dated 9/9/15, identified, "... assessment of area to coccyx ... measures 1.1 x 0.3 cm ... appears to be healing ...", and identified an intervention of, "...turning and repositioning program every 1 hour when in bed and chair. Current treatments & repositioning is appropriate."	F 314	re-educated on resident repositioning on October 14th, 15th and 16th 2015. A Repositioning Monitor was developed and will be completed to ensure that residents are repositioned according to care plan to promote wound healing and prevention of pressure ulcers. The Director of Nursing or designee will complete this monitor once weekly for four weeks and then quarterly monitors will be completed and presented at the quality assurance meeting for one full year	

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F 314	Continued From page 7 When interviewed on 9/10/15, at 9:32 a.m. registered nurse (RN)-A stated R4 had a "split in coccyx" and should be repositioned every hour to reduce the pressure on her coccyx. Further, RN-A stated staff are to be off loading her from her coccyx for "a few minutes", and just moving her slightly in her chair was not sufficient to relieve pressure from R4's coccyx. During an interview on 9/10/15, at 11:05 a.m. the director of nursing (DON) stated R4 should be repositioned every hour by removing her from her wheel chair and offloading her for at least one full minute, adding R4 should be laid down in her bed to reposition her appropriately. A policy for repositioning was requested, but none provided.	F 314		

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	245423	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/09/2015**

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K 000	INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Chosen Valley Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or Or by email to: Marian.Whitney@state.mn.us or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/01/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Chosen Valley Care Center is a 1-story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1975 and was determined to be of Type V(111) construction. In 1998, an addition was constructed and was determined to be of Type V(111) construction. In 2001, an addition was constructed and was determined to be of Type II(000) construction. In 2002, a canopy was constructed and was determined to be of Type V(111) construction. The construction type was changed after review of the architectural drawings that are on hand for the facility. Because the original building and the 3 addition are of the same type of construction and meet the construction type allowed for existing buildings, The facility will be surveyed as a Type V(111) building. The building is fully sprinkled. The facility has a fire alarm system with full corridor smoke detection and that is monitored for automatic fire	K 000		

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K 000	Continued From page 2 department notification. The facility has a capacity of 78 beds and had a census of 75 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 025 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain 1 of several smoke barrier walls construction that meet the requirements of NFPA 101 - 2000 edition, Sections 19-3.7.3 and 8.3. This deficient practice could affect residents, staff and visitors by allowing smoke to propagate from one smoke compartment to another. Findings include: On facility tour between 11:30 AM to 2:30 PM on	K 025	The Director of Environmental Services placed fire caulk around the 2 inch conduit on 9/23/15. A monitor to check all smoke barriers within facility will be completed quarterly by the Director of Environmental Services or designee and reported at the quality assurance meeting for one full year.	10/19/15

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K 025	Continued From page 3 09/09/2015, observation revealed that there was a penetration around a 2 inch conduit pipe that is passing through the smoke barrier wall above the corridor smoke barrier doors by resident room E101 in the E-Wing. This deficient condition was verified by the Maintenance Supervisor.	K 025		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was found that the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that	K 056	The Director of Environmental Services contracted with Viking Automatic Sprinkler Company of Rochester, MN to install 2 new sprinkler heads in laundry room to ensure that all sprinkler heads are of the same type, this work was performed on 9/28/15. Chosen Valley Care Center has purchased the necessary sprinkler heads from Viking Automatic Sprinkler Company	10/19/15

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K 056	Continued From page 4 would affect the residents, visitors and staff of the facility. Findings include: On facility tour between 11:30 AM to 2:30 PM on 09/09/2015, observations have revealed that the following deficient practices were found to be affecting the facility's fire sprinkler system: 1) The facility's spare sprinkler head box did not contain at least 2 of every style and type of fire sprinkler heads, 2) There are two different types of sprinkler head mixed in the same compartment, there are 2 quick response heads mixed in with standard type heads located in the laundry room. This deficient condition was verified by the Maintenance Supervisor.	K 056	to ensure that there are 2 of every style and type in sprinkler head box. The Director of Environmental Services or designee will check sprinkler head box quarterly in conjunction with quarterly sprinkler test.	
K 069 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was determined that the facility has failed to ensure the accessibility to the manual activation pull station for the hood suppression system is in compliance with the requirements of NFPA 96 Fire Extinguishing systems (98) section 7-5.1. This deficient condition would delay the activation of the kitchen's hood suppression system in the event of a fire above the cooking area of the	K 069	The Director of Environmental Services contracted with Viking Automatic Sprinkler Company of Rochester, MN. to relocate the manual activation pull station for the kitchen hood suppression system. This work was performed on 9/24/15 and will be monitored monthly in conjunction with Kitchen sanitation and safety inspection checklist. This checklist results will be	10/19/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/09/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOSEN VALLEY CARE CENTER	**1102 LIBERTY STREET SOUTHEAST CHATFIELD, MN 55923**

(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) COMPLETION DATE
K 069	Continued From page 5 kitchen; and could negatively affecting 18 of 74 residents, staff, and visitors of the facility. Findings Include: On facility tour between 11:30 AM to 2:30 PM on 09/09/2015, observation revealed that the manual pull station for the kitchen's hood suppression system was obstructed by a shelf storing dishes. This deficient condition was verified by the Maintenance Supervisor.	K 069	reviewed quarterly and reported at the quality assurance meeting by the Director of Dietary services for one full year.	