Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 3, 2026

Administrator
Browns Valley Health Center
114 JEFFERSON STREET SOUTH
BROWNS VALLEY, MN 56219

RE: CCN: 245564
Cycle Start Date: April 21, 226

Dear Administrator:

On May 21, 2026, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 24, 2026

Administrator
Browns Valley Health Center
114 JEFFERSON STREET SOUTH
BROWNS VALLEY, MN 56219

RE: CCN:245564
Cycle Start Date: April 21, 2026

Dear Administrator:

On April 21, 2026, a survey was completed at your facility by the Minnesota Department(s) 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Stacy Line, BSN, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
2312 College way
Fergus Falls, 56537
Email: stacy.line@state.mn.us

Office: 218-332-5159

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 July 21, 2026 (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).

In addition, if substantial compliance with the regulations is not verified by October 21, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900

Saint Paul, MN 55164-0900

Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245564	A. BUILDING B. WING	04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Browns Valley Health Center	114 JEFFERSON STREET SOUTH , BROWNS VALLEY, Minnesota, 56219

(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
E0000	Initial Comments On 4/20/26 to 4/21/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		05/01/2026
F0000	INITIAL COMMENTS On 4/20/26 to 4/21/26, a federal recertification survey was conducted using the Risk-Based Survey (RBS) process at your facility. Your facility was not in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. 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 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		05/01/2026
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.	F0550	Based on observation, interview, and record review, the facility failed to ensure grooming preferences specifically shaving in R2 and R6. The residents identified in the POC were provided with shaving care promptly. R2 and R6's Care Plans /Kardex were updated to reflect grooming preferences. All residents with facial hair have the potential to be affected. A 100% audit of all current residents with facial hair was conducted to ensure:	05/01/2026

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245564	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Browns Valley Health Center	**114 JEFFERSON STREET SOUTH , BROWNS VALLEY, Minnesota, 56219**

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F0550 SS = D	Continued from page 1 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dignity was maintained for 2 fo 2 residents (R2, R6) who were reviewed for activity of daily living (ADLs). R2's quarterly minimal data set (MDS) dated 3/24/26, identified moderate cognitive impairment, and had a diagnosis that included heart failure, hypertension, and diabetes. R2 was dependent on staff for activities of daily living (ADLs) such as dressing, toileting, and personal hygiene, including shaving and combing hair. R2's care plan revised on 12/17/25, identified R2 required assistance from staff with personal hygiene. R2 had impaired cognitive function.	F0550	Continued from page 1 Grooming preferences are documented Grooming aligns with resident preferences Any identified concerns were corrected, and Care Plans/Kardex were updated. All nursing staff, including CNAs, LPNs, and RNs, received Education on policies. Activities of Daily Living Dignity Education will be completed by the Director of Nursing (DON) or designee within 14 days of POC acceptance. New hires will receive this education during orientation. Residents lacking documented grooming preferences had preferences obtained via resident interview and/or responsible party consultation. Care plans were updated to reflect individualized grooming preferences. The Director of Nursing (DON), Unit Managers, or designee will conduct audits using a Facial Hair Grooming Audit Tool to ensure: Care provided aligns with preferences Grooming is completed appropriately Audit Schedule: Weeks 1–4: 3 residents, 3 times weekly Months 2–3: 5 residents per weekly Ongoing: 5 residents monthly Audit results will be reported to the facility's Quality Assurance and Performance Improvement (QAPI) Committee for review and further action as needed.	05/01/2026

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F0550 SS = D	Continued from page 2 R2's care sheet dated 4/21/26, identified R2 required assistance from staff with personal hygiene. During an observation on 4/20/26 at 6:31 p.m., R2 had facial hair approximately 1 millimeter (mm) on chin. R2 was unable to verbalize whether the facial hair bothered her. During an observation on 4/21/26 at 8:39 a.m., R2 had facial hair approximately 1 mm on chin. During an interview on 4/20/26 at 7:05 p.m., with family member (FM)-B indicated having facial hair would bother R2 and would expect staff to keep R2 shaved. During an interview/observation on 4/21/26 at 9:42 a.m., nursing assistant (NA)-B verified R2 needed assistance with ADLs. NA-B verified R2 had approximately 1 mm of facial hair, and R2 should be shaved per her preference. During an interview/observation on 4/21/26 at 10:14 a.m., licensed practical nurse (LPN)-A verified R2 needed assistance with activities of daily living, such as shaving. LPN's expectation would be for staff to shave residents per their preference. LPN-A verified R2 had approximately 1 mm of facial hair on her chin and should have been shaved. During an interview on 4/21/26 at 10:22 a.m., director of nursing (DON) expectation would have been for staff to shave residents per their preference. DON indicated this was important related to dignity. R6's quarterly Minimum Data Set (MDS) dated 4/13/26, identified R6 had severe cognitive impairment and had diagnoses which included: dementia, hypertension and arthritis. R6 was dependent on staff for personal hygiene and dressing. R6's MDS also identified R6 had no rejection of care exhibited. R6's comprehensive care plan revised 1/16/26, identified R6 had self-care performance deficit related to aggressive behavior and dementia. R6 was	F0550	Continued from page 2 The QAPI Committee will determine the need for ongoing monitoring to ensure sustained compliance. All corrective actions and staff education will be completed by: _____05/01/2026_____ (Date)	05/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245564	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/21/2026

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F0550 SS = D	Continued from page 3 totally dependent on staff for personal hygiene. Review of R6's progress notes from 3/21/26 to 4/21/26, lacked documentation of refusal of facial hair removal. During observation on 4/20/26 at 6:57 p.m., R6 was in wheelchair in common area participating in an activity. R6 had a large amount of white facial hair across her chin and above her lip approximately six to seven millimeters (mm) long. During observation on 4/21/26 at 8:54 a.m., R6 was dressed in street clothes in wheelchair in dining room finishing breakfast. R6 continued to have white facial hair across her chin and above her lip approximately six to seven mm long. During phone interview on 4/21/26 at 9:24 a.m., family member (FM)-A stated it would bother R6 if she knew she had facial hair visible. FM-A indicated she had recently purchased a new razor for R6 and would expect staff to remove R6's facial hair if present. During interview on 4/21/26 at 9:34 a.m., nursing assistant (NA)-A stated R6 was dependent on staff for cares and did not think R6 refused cares. NA-A stated she had not assisted R6 with morning cares that day, but if seen R6 had facial hair would have shaved R6 with her razor. NA-A indicated if R6 refused she would let the nurse know. NA-A viewed R6 and verified R6 had facial hair present. During interview on 4/21/26 at 9:42 a.m., trained medication aide (TMA)-A verified R6 had facial hair visible on her face. TMA-A stated R6 had her own razor in her room. TMA-A stated generally residents were shaven on bath days, but she would do it more often if present. TMA-A stated usually R6 would allow staff to shave her facial hair, but if R6 refused she would try again later or have a different person try. During interview on 4/21/26 at 10:17 a.m., licensed practical nurse (LPN)-A stated residents should be shaven every morning before they left their rooms. LPN-A indicated TMA-A had just shaven R6 after we spoke. LPN-A indicated it was important to remove resident's facial hair for their dignity. If a resident refused, she would expect staff to reapproach or have someone else do it. During interview on 4/21/26 at 10:25 a.m. director of nursing (DON) stated facial hair removal was based on resident preference. If a resident preferred to	F0550		05/01/2026

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F0550 SS = D	Continued from page 4 have facial hair present, she would expect it to be written on their care plan, if not, she would expect the resident to be free of facial hair. DON indicated shaving should be done with morning cares and was important for their dignity. Review of facility policy titled Dignity revised on 4/17/23, identified residents shall be groomed as they wish to be groomed (e.g. hair styles, nails, facial hair.) Review of the facility policy titled Activities of Daily Living (ADL) dated 9/23/25, identified activities of daily living (ADLs) include, but are not limited to: Personal hygiene and grooming- bathing, oral care, hair care, shaving, and nail care. Nursing and direct care staff will provide ADL assistance in accordance with the individualized care plan. Staff will encourage residents to actively participate in their own care to the degree they are able. All ADL care will be delivered respectfully, maintaining privacy, dignity, and honoring resident choice.	F0550		05/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245564	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **04/21/2026**

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/21/2026. At the time of this survey, Browns Valley Health Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99 Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE 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. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K0000		05/08/2026

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245564	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **04/21/2026**

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K0000 Bldg. 01	Continued from page 1 By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Browns Valley Health Care is a 1-story building with a partial basement constructed at 2 different times. The original building was constructed in 1970 and was determined to be of Type II(111) construction. In 2001 an addition was added to the north that was determined to be of Type II(111) construction. Because the original building and the addition are of the same type of construction, meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinkler protected, and has a fire alarm system with corridor smoke detection and smoke detection in spaces open to the corridors. The fire alarm system is monitored for automatic fire department notification. The facility has a capacity of 31 beds and had a census of 27 on the day of the survey. The requirements at 42 CFR, Subpart 483.70(a) are	K0000		05/08/2026

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K0000 Bldg. 01	Continued from page 2 NOT MET.	K0000		05/08/2026
K0222 SS = D Bldg. 01	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING	K0222	On 4/21/2026 11:26AM It was revealed by observation that the delayed egress door by room 164 did not have a readily visible, durable sign on the door stating: “PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS.” Permanent signage has been placed on all delayed egress doors in our building including the one near 164 that reads “PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS” by Maintenance Director Andy Raw on 4/21/2026.	04/21/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245564	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **04/21/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Browns Valley Health Center	**114 JEFFERSON STREET SOUTH , BROWNS VALLEY, Minnesota, 56219**

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K0222 SS = D Bldg. 01	Continued from page 3 ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain delayed egress doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.2.4, and 7.2.1.6.1.1(4). This deficient finding could have an isolated impact on residents within the facility. Findings include: On 04/21/2026 at 11:26 AM, it was revealed by observation that the delayed egress door by Room 164 did not have a readily visible, durable sign on the door stating: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0222		04/21/2026
K0353 SS = D Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.	K0353	On 4/21/2026 at 10:54AM. It was revealed by observation that the sprinkler heads in the Laundry Room were showing signs of loading with dust and debris. POC K0353: Laundry room sprinkler heads were cleaned by maintenance director Andy Raw on 4/21/2026. Furthermore, all facility sprinkler heads will be audited quarterly starting on 05/08/2026 and reported on at our quarterly QA meeting.	04/21/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245564	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **04/21/2026**

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K0353 SS = D Bldg. 01	Continued from page 4 a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.1.1.2(5). This deficient finding could have an isolated impact on residents within the facility. Findings include: On 04/21/2026 at 10:54 AM, it was revealed by observation that the sprinkler heads in the Laundry Room were showing signs of loading with dust and debris. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0353		04/21/2026
K0761 SS = D Bldg. 01	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are	K0761	On 4/24/2026 at 11:04AM, It was revealed by observation that the fire door protecting the elevator lobby from the corridor did not positively latch when released from the magnetic hold-open device. POC K0761: New hardware that latches has been ordered and will be installed by maintenance director Andy Raw on or before 05/08/26. In addition to the yearly door inspection, the elevator lobby doors will be inspected quarterly to ensure that the doors are latching. Starting on 05/08/2026 results will be shared at the quarterly QA meeting.	05/08/2026

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K0761 SS = D Bldg. 01	Continued from page 5 maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain fire doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.6, and 4.6.12, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, sections 5.2, and 5.2.9. This deficient finding could have an isolated impact on residents within the facility. Findings include: On 04/21/2026 at 11:04 AM, it was revealed by observation that the fire door protecting the elevator lobby from the corridor did not positively latch when released from the magnetic hold-open device. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0761		05/08/2026