Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered via Email
July 25, 2024

Administrator
Apple Valley Village Health Care Center
14650 Garrett Avenue
Apple Valley, MN 55124

RE: CCN: 245264
Cycle Start Date: July 18, 2024

Dear Administrator:

On July 18, 2024, a 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), 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:

Pete Cole, RN Regional Operations Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

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 October 18, 2024 (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 January 18, 2025 (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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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:

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,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered via Email
July 25, 2024

Administrator
Apple Valley Village Health Care Center
14650 Garrett Avenue
Apple Valley, MN 55124

Re: State Nursing Home Licensing Orders
Event ID: 1H1111

Dear Administrator:

The above facility was surveyed on July 15, 2024 through July 18, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Pete Cole, RN Regional Operations Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245264	A. BUILDING: _____ B. WING _____	7/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	14650 GARRETT AVENUE APPLE VALLEY, MN

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 641	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately complete the Minimum Data Set (MDS) assessment for 2 of 3 residents (R145, R108) reviewed. Findings include: The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (RAI), dated October 2023, identified the purpose of the RAI process was to help ensure holistic care was provided. The RAI stated, "The RAI process, which includes the Federally mandated MDS is the basis for an accurate assessment of nursing home residents." In addition, "Tracking records and Discharge assessments reporting are required on all residents in the SNF (skilled nursing facility)". R145 R145's admission Minimum Data Set (MDS) dated 3/29/24, indicated R145 admitted to facility on 3/26/24, and had a diagnosis of fracture of superior ramus of right pubis (fracture of right pubic bone). R145's Discharge-return not anticipated MDS dated 4/24/24, was marked as "A2105. Discharge Status" with answer as discharging to, "04. Short-Term General Hospital (acute hospital, IPPS)". R145's progress note, dated 4/18/24, summarized a planned discharged to a memory care facility on 4/24/24 at 10:30 a.m. The note indicated homecare service was recommended and would be provided along with company planned to provide the services. The documents indicated R145's primary care providers were located at "ALF" (assisted living facility). R145's subsequent progress note, dated 4/24/24, indicated, "Resident stable this morning, took all her meds, up for breakfast. Resident discharged to her Memory care facility at around 10:30 am. Discharge orders and medications handed to the daughter." R145's Physician Discharge Summary, dated 4/25/24, indicated R145's discharge date was 4/24/24. Under the discharge location section, the following options were available to select from for discharge location: home, assisted living facility, another skilled nursing facility, acute care/hospital, other (specify), not applicable, resident expired. With a radio-button answer "home" was answered with a reason for discharge was a typed answer "discharged home."

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245264	A. BUILDING: _____ B. WING _____	7/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	14650 GARRETT AVENUE APPLE VALLEY, MN

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 641	Continued From Page 1

R145's medical record was reviewed and lacked evidence that R145 had been discharged to a short-term general hospital as recorded on MDS (dated 4/24/24).

R108

R108's quarterly MDS dated 6/11/24, indicated R108 admitted to facility on 12/21/21. R108's diagnoses included: dementia, gastrostomy status (a surgical opening into the stomach for nutritional support - tube feeding) with impaired cognition. Under section GG Functional Abilities and Goals - in section GG0130 Self-care - in section A5 eating- assessed R108's ability to use suitable utensils to bring food and/or liquids to the mouth and swallow food and/or liquids once the meal is placed before the resident. R108 was coded as "01. Dependent" which definition is: "helper does ALL of the effort. Resident does none of the effort to complete the activity.

R108's progress note, dated 6/13/24, R108 was being followed by registered dietician "high nutritional risk r/t (related to) reliance on TF (tube feeding) due to NPO (nothing by mouth) status. Document further indicated R108's "total nutrition provided via feeding tube" was "NPO" due to oropharyngeal dysphagia (difficulty swallowing food)

On 7/17/24 at 2:06 p.m., R108 was observed lying in bed and appeared comfortable. R108's tube feeding was running and R108 was receiving her nutrition via her tube feeding. R108 was laying with her eyes closed and hummed responses when asked questions.

On 7/18/24 at 7:54 a.m., licensed practical nurse (LPN)-A stated they were familiar with R108 and verified they had worked with her often. LPN-A stated that "she never takes anything by mouth. She has a G-Tube (tube feeding), and everything goes in that."

On 7/18/24 at 9:32 a.m., registered nurse (RN)-E verified that they completed MDS's for the facility. RN-E verified R145's discharge MDS dated 4/24/24, was coded incorrectly. RN-E verified that R145 was discharged to an Assisted Living Memory Care and not the hospital.

In a follow-up interview on 7/18/24 at 10:00 a.m., RN-E verified R108's quarterly MDS dated 6/11/24, was coded incorrectly. RN-E verified it should have been coded as "N/A" as R108 was fed via tube feeding only. RN-E stated it was important that information on the MDS was accurate as payment was determined by the responses. RN-E stated they had since adjusted the MDS assessment.

On 7/18/24 at 11:05 a.m., director of nursing (DON) stated accuracy of MDS was important as that was how the facility received payment, and the MDS assessments needed to accurately reflect the cares the facility provided.

A Facility policy titled MDS Assessments, reviewed 3/28/24, was provided. The document indicated, "The Long-Term Care Facility Resident Assessment Instrument (RAI) process would be used to complete a

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245264	A. BUILDING: _____ B. WING _____	7/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	14650 GARRETT AVENUE APPLE VALLEY, MN

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 641	Continued From Page 2 comprehensive assessment of a resident's needs, strenghts, goals, life history, and preferences. Assessments would be completed per the guidelines in the RAI Manual, and include the Care Area Assessment (CAA) and care panning processes in compliance with Centers for Medicare and Medicaid Services (CMS) and any state regulations."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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
E 000	Initial Comments On 7/15/24 - 7/18/24, a survey for compliance with CMS Appendix Z, the Emergency Preparedness Requirements, was conducted during a standard recertification survey. The facility was found 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.	E 000		
F 000	INITIAL COMMENTS On 7/15/24 - 7/18/24, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was found not in compliance. 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.	F 000		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances.	F 585	***This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet***	

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

Dore Shan | Administrator | 8-7-2024

Approved: Pete Cole Digitally signed by Pete Cole Date: 2024.08.08 12:28:19 -05'00'

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 585	Continued From page 1 §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her	F 585	***requirements established by State and Federal law.*** **F585: Addressing Grievances and Ensuring Resolution Communication** **Policy Statement** It is the policy of Cassia Apple Valley Village Health Care Center to comply with the regulation cited under F585, ensuring that all resident grievances are tracked through the facility-established grievance process and that residents or their representatives are updated on the resolution of the grievances. **Plan of Correction** **Regarding Cited Resident:** It is cited that the facility failed to ensure that a resident's or resident representative's grievances were tracked through the facility-established grievance process, and the resident representative was not updated on the resolution of the grievance for Resident R55, who reported missing clothing items and care concerns. 1. **Immediate Actions Taken:** - Immediately acknowledged the grievances reported by Resident R55's representative regarding missing clothing items and care concerns. - Documented the grievance in the facility's grievance log, ensuring all details were accurately recorded.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 585	Continued From page 2 grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;	F 585	Documented the missing item using the facility lost item form. - Communicated and sought feedback from Resident R55 and the resident representative to ensure their concerns were fully addressed. **Actions Taken to Identify Other Potential Residents Having Similar Occurrences:** - **Policy Review:** Reviewed the facility's policies and procedures related to handling grievances and lost items and determined no changes necessary. - Reviewed the missing item log and grievance log for the past 6 months to ensure appropriate follow-up and documentation. **Measures Put in Place to Ensure Deficient Practice Does Not Recur:** - **Staff Training:** - Conducted training sessions for all staff members on the facility's grievance process, emphasizing the importance of tracking grievances and updating residents and their representatives. - Conducted training sessions for all staff members on the facility's lost items process, location of forms, completion of forms after initial search and who to turn forms into for appropriate. - Re-educated nursing staff regarding facility mechanical lift policy.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 585	Continued From page 3 (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a resident/ resident representative's voiced grievances, were tracked through the facility-established grievance process, and the resident representative was updated on the resolution of the grievance for 1 of 1 residents (R55) who had reported missing clothing items and care concerns. Findings include: MECHANICAL LIFT R55's quarterly Minimum Data Set (MDS) dated 6/4/24, indicated R55 had moderate cognitive impairment and was dependent on staff for hygiene, bathing, and transferring. R55's care plan dated 3/3/23, indicated that R55 required the total assistance of two staff members using a full body lift for transfers. An email correspondence from resident representative (RR)-B and registered nurse (RN)-D, the unit nurse manager, dated 6/21/24 at	F 585	**Effective Implementation of Actions Will Be Monitored By:** • The **Director of Social Services** or designee will audit each grievance for three months to ensure compliance with the grievance process and appropriate follow-up documentation. Results of these audits will be reviewed by the facility QAPI committee, which will decide if further monitoring or audits are recommended. • The **Director of Social Services** or designee will audit 1 lost item per week for three months to ensure compliance with the lost item process and appropriate follow-up documentation. Results of these audits will be reviewed by the facility QAPI committee, which will decide if further monitoring or audits are recommended. **Those Responsible to Maintain Compliance:** • The **Director of Nursing** or designee is responsible for maintaining compliance. **Completion Date for Certification Purposes Only:** • **September 4, 2024** By taking these steps, the facility has ensured that Resident R55's grievances were properly tracked and resolved, and that the resident representative was kept	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 585	Continued From page 4 7:43 p.m., indicated RR-B had witnessed an unknown staff member use a mechanical lift to transfer R55 to bed independently. Another email correspondence from resident representative (RR)-B and RN-D dated 6/24/24 at 10:09 p.m., indicated RR-B had witnessed an unknown staff member use a mechanical lift to transfer R55 to bed by independently. A Performance Improvement Form dated 7/2/24 at 3:10 p.m., indicated a meeting had occurred between RN-D and nursing assistant (NA)-F and confirmed NA-F had used a full-body mechanical lift to transfer R55 by themselves. The form indicated what action management had taken and mechanical lift education that had been provided. A Performance Improvement Form dated 7/5/24 at 2:31 p.m., indicated a meeting had occurred between RN-D and NA-G and confirmed NA-G had used a full-body mechanical lift to transfer R55 by themselves. The form indicated what action management had taken and mechanical lift education had been provided. A review of grievances from 1/16/24 to 7/16/24 was completed and identified nine grievances for the six-month period. The facility lacked a grievance form for R55. R55's record was reviewed and lacked evidence that R55's concerns were addressed through the facility grievance process to determine what, if any, other actions were needed to ensure all staff were aware of the care plan and, if needed, re-educated to ensure appropriate, safe transfers for R55.	F 585	informed throughout the process. These actions demonstrate the facility's commitment to addressing and resolving grievances promptly and effectively.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 585	Continued From page 5 During an interview on 7/16/24 at 1:15 p.m., resident representatives (RR)-A and RR-B stated they visited R55 daily and had a camera in R55's room for observing when R55 needed assistance. RR-A and RR-B stated they had communicated multiple concerns with the facility they felt had not been resolved. RR-A stated she had emailed and discussed in person a concern regarding two different staff members, on two separate occasions, using the mechanical lift by themselves to transfer R55 when they thought two staff members were needed. RR-A stated she did not feel R55 was safe knowing this had occurred and not knowing what, if anything, the facility had done to correct this issue that could have caused harm to R55. RR-A stated they now felt like they had to continuously watch the camera to ensure RR-A was receiving safe care and they should not have to do this. During an interview on 7/17/24 at 8:50 a.m., RN-D, the unit nurse manager, stated she had a conversation with R55's representatives and had realized that she was not receiving emails from them due to an IT issue. RN-D stated she became aware of the representative concern regarding the one-person mechanical lift use a couple of weeks ago. RN-D stated education and final warnings were given to the two staff members involved on their next shift. RN-D stated she had informed the family that would look into this concern and complete education with the two staff members involved but did not file a formal grievance and had not followed up with R55's representatives after education and the investigation was completed. RN-D stated she talked with R55's family often and if they had continued concerns regarding this issue, they could have asked for an update.	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 585	Continued From page 6 During an interview on 7/18/24 at 10:04 a.m., the director of social services (DSS), the grievance official, stated floor staff had access to grievances forms they could fill out and then bring to her so she could track the issue and make sure the concern was addressed by all of the appropriate parties. The DSS stated she "babysat" the concern as it goes through the grievance process to ensure it reaches resolution and then ensures that resolution is brought to the resident/ resident representative. The DSS stated she expected staff to complete a grievance form when the issue had occurred on more than one occasion or could not be fixed instantly. The DSS stated there was value in having documentation so the issues could be tracked. During an interview on 7/18/24 at 11:44 a.m., the director of nursing (DON) stated the DSS was in charge of grievances and grievance forms could be found throughout the facility form for residents and families to complete when they had a concern. The DON stated if a concern was brought to a staff member, it was up to that staff member's discretion to decide if an official grievance needed to be completed. The DON stated the facility did not have official criteria to determine when filing a grievance was necessary. The DON stated they had not filed an official grievance regarding staff using a mechanical lift to assist R55 because the issue was followed up on so quickly and taken care of "right away". The DON stated that RN-D had informed R55's representative that education would be provided when the concern was brought forward. The DON stated because education had been given to staff "immediately" she did not think it was necessary to follow up with the representatives after the	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 585	Continued From page 7 investigation and education were completed. MISSING ITEMS On 7/17/24 at 3:02 p.m., a request was made for any reports of missing items for R55 in the last six months. A reply was received on 7/17/24 at 3:21 p.m., from the Director of Social Services (DSS) indicating no missing items were reported for R55 in 2024. During an interview on 7/16/24 at 1:15 p.m., RR-A stated they had noticed multiple of R55's clothing items go missing in the last few months and they had notified facility staff however had not heard anything about it since then. During an interview on 7/17/24 at 2:13 p.m., nursing assistant (NA)-A stated she had noticed a few of R55's outfits go missing over the last few months and she had looked for the outfits however had never found them. NA-A stated she did not fill out a missing laundry form and was unsure if anyone else had. During an interview on 7/18/24 at 10:29 a.m., RN-D, the nurse manager of the unit, stated she was not aware of any of R55's personal items missing however if it had happened, she would have expected a report to have been sent to the DSS. During an interview on 7/18/24 at 12:19 p.m., the DSS stated the facility used a separate system for tracking lost items than for following grievances. The DSS stated she was in charge of tracking lost items and had a form she expected any staff member to fill out if they noticed or were notified of a resident missing a personal item.	F 585		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 585	Continued From page 8 The DSS stated when she was notified of a missing item, a further investigation was completed including a facility-wide email and monthly summary that she followed. The DSS stated that if an item was not recovered, they were "pretty flexible" about reimbursing residents for items that had gone missing. The DSS confirmed that she had reviewed her records and had not found evidence that a form had been completed for R55. The facility Grievance policy dated 10/20/23, indicated grievances could be filed orally or in writing, and "all grievances" would be responded to within seven days. The policy indicated the staff person receiving the concern would initiate the grievance form and it would then be routed to the grievance official. The grievance official would ensure any necessary investigations were completed as well as corresponding documentation. The policy indicated that once the grievance investigation was completed, the form as well as the written grievance decision would be sent to the facility administrator for review. The documentation would also be sent to the facility's "quality assurance person" for review and tracking using a grievance tracking log.	F 585		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure routine	F 677	**F677: Addressing Nail Care Deficiency** **Policy Compliance** It is the policy of Cassia Apple Valley Village Health Care Center to comply with the regulation cited (F677). **Plan for Continued Compliance** To assure continued compliance, the following plan has been put into place:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 677	Continued From page 9 grooming and personal hygiene care (i.e., nail care) was provided for 1 of 3 residents (R60) reviewed for activities of daily living (ADLs) and who was dependent on staff for such care. Findings include: R60's admission Minimum Data Set (MDS), dated 4/29/24, identified R60 had moderate cognitive impairment, demonstrated no delusional thinking, and did not have diabetes mellitus. Further, the MDS identified R60 required supervision and/or touching assistance to complete personal hygiene cares. On 7/15/24 at 2:21 p.m., R60 was observed in his wheelchair while in his room. R60 had a visible, slight finger contracture present on his left hand but had multiple long fingernails present on both hands with the edge of the nail being several millimeters (mm) long on some of them and some nails having a dark-colored debris present under the edge. R60 was interviewed and stated he was getting help with bathing "once a week" but needed help with his fingernail clipping adding, "These [nails] are too long." R60 stated he thought he had been asked about clipping them prior but was not sure when or why they hadn't been clipped. R60 reiterated he wanted his nails clipped adding, "Yea." R60's care plan, dated 6/21/24, identified R60 had multiple medical conditions including Parkinson's Disease and chronic kidney disease (CKD). The care plan outlined R60 required assistance to complete his ADLs along with various interventions including, "GROOMING: Staff to provide assist with grooming." The care plan lacked any intervention or direction on nail	F 677	**Regarding Cited Resident** • It is cited that nail care was not consistently provided or documented for R60 whose nails were not attended to or clipped. Nail care was only recorded on the MAR/TAR if applicable due to diabetic status requiring licensed staff completion of care, and there was a lack of documentation if care was offered and refused. **Actions Taken to Identify Other Potential Residents Having Similar Occurrences** • All residents assessed for nail care needs and cares provided by appropriate staff. • Cassia Nursing Assistant Standard Cares Policy and Procedure was reviewed and determined no changes necessary. **Measures Put in Place to Ensure Deficient Practice Does Not Recur** 1. **Staff Training** - Conducted comprehensive training sessions for all nursing staff on the importance of nail care being offered and provided weekly and PRN. Nursing staff educated on proper documentation of refusals and notation of resident preference if resident prefers to have nails at a longer length.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 677	Continued From page 10 care and/or preferred nail length, if applicable. R60's most recent Visual Body Inspection(s), dated 7/3/24 and 7/10/24, were reviewed. These identified R60 had no new skin impairments (i.e., bruises, pressure sores); however, lacked detail or evidence R60's nails had been reviewed with the completed skin check. R60's Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 7/2024, identified R60's provided and recorded medications along with his completed treatments. These both lacked evidence of any nail care had been completed or offered during the month period thus far. On 7/16/24 at 1:32 p.m., nursing assistant (NA)-A was interviewed. NA-A explained they had worked with R60 a few times since he admitted to the care center and stated the NA(s) were responsible for nail care if the resident was not diabetic. NA-A stated nail care should be completed weekly adding, "We do with the baths." NA-A stated R60 was typically accepting of care and, at request of the surveyor, observed R60's fingernails. NA-A verified their length and condition and expressed they were unsure when they had been last clipped or trimmed. NA-A stated nail care, either when offered or completed, was not routinely documented in their charting and expressed, "Maybe the nurse [does]." NA-A verified R60 would need staff help to clip his fingernails. R60's entire medical record including progress notes was reviewed and lacked evidence what, if any, nail care had been offered or completed for R60 within the past several weeks.	F 677	**Effective Implementation of Actions Will Be Monitored By** The **Director of Nursing** or designee will audit 10 residents' nail care and documentation per unit per week for three months to ensure that nail care is being provided and documented as required. Results of these audits will be reviewed by the facility QAPI committee, and they will make the decision if further monitoring/audits are recommended. **Those Responsible to Maintain Compliance** The **Director of Nursing** or designee is responsible for maintaining compliance. **Completion Date for Certification Purposes Only** Completion date: September 4, 2024 By implementing these measures, we have addressed the deficiency related to nail care and ensured that all residents receive the necessary care in a timely and documented manner.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 677	Continued From page 11 When interviewed on 7/16/24 at 1:40 p.m., registered nurse (RN)-C explained nail care should be completed with the weekly bathing schedules and expected the care completed adding, "They should be done." RN-C stated the nurses only recorded nail care on the MAR/TAR, if applicable, to their knowledge and verified the NA(s) were able to clip or trim fingernails for non-diabetic residents. On 7/16/24 at 1:51 p.m., registered nurse unit managers (RN)-A and RN-B were interviewed. RN-A explained nail care should be done with the scheduled bathing but could also be done "whenever needed." RN-A stated they expected fingernails and toenails to be checked and, if needed, attended to or clipped. RN-A stated nail care was "not necessarily" documented unless it was offered and refused adding nail care was more "a standard of care with a bath." RN-A verified R60 likely needed help to clip his fingernails and stated it should be completed for "proper hygiene." RN-A stated they would review the medical record and provide documentation of nail care if located. No further medical record information was received. A provided Nursing Assist Standard Cares policy, dated 3/2024, identified nursing staff would provide quality care to those served and listed standard cares which would be provided unless indicated on the care plan. The list of cares or services included, "8. Nail care weekly and PRN [as needed]. Nails should be short and clean."	F 677		
F 684 SS=D	Quality of Care	F 684	**F684: Addressing and Resolving Skin Condition Deficiency**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 684	Continued From page 12 CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a developed skin condition was comprehensively assessed and, if needed, acted upon or monitored to ensure healing for 1 of 1 resident (R141) reviewed who had large areas of dry, flaking skin present on their leg. Findings include: R141's admission Minimum Data Set (MDS), dated 6/28/24, identified R141 had intact cognition and demonstrated no delusional thinking. Further, the MDS outlined R141 had several medical conditions including anemia; however, R141 had no current wounds, skin ulcers, or other skin-related problems. R141's Nursing Admission, dated 6/23/24, identified R141 admitted from the hospital on the same date and outlined multiple body systems to review along with areas to record what, if any, conditions or issues were identified. The completed evaluation identified no edema was present on R141's lower extremities, however, there was no recorded spaces or areas to record	F 684	It is the policy of Cassia Apple Valley Village Health Care Center to comply with F684. To assure continued compliance, the following plan has been put into place; **Regarding Cited Resident:** It is cited that the facility failed to ensure a developed skin condition was comprehensively assessed and, if needed, acted upon or monitored to ensure healing for 1 of 1 resident (R141) reviewed who had large areas of dry, flaking skin present on their leg. Prior to survey exit, R141 was started on a new topical treatment to attend to his dry skin and routine monitoring per facility policy and protocol will continue. **Actions taken to identify other potential residents having similar occurrences:** • All residents will be reviewed within the week on scheduled bath day for skin impairment concerns and appropriate follow-up will be done, if any is indicated, after assessment completion. **Measures put in place to ensure deficient practice does not recur:** 1. **Staff Training**: - Conducted training sessions for all nursing staff on the importance of skin assessments, early identification of skin issues, communication of skin	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 684	Continued From page 13 what, if any, skin conditions were present. R141's care plan, dated 6/24/24, identified R141 was at risk for skin integrity alteration due to multiple medical conditions and decreased mobility. The care plan listed a goal which read, "Skin will remain intact through 90 days," along with interventions including encouraging him to elevate his heels in bed, pressure-relieving cushions, a licensed staff visual body inspection weekly and, "[Nursing assistant] to observe skin daily during cares and notify nurse promptly of any areas of concern." On 7/15/24 at 7:02 p.m., R141 was observed lying in bed while in his room. R141 was interviewed and explained he admitted to the care center after having a fall at his home where he sustained a hematoma (a collection of blood trapped outside the vessel under the skin) on his right leg. R141 pulled up his right pant leg which showed a large, black-colored area on the swollen lateral right thigh; however, nearly the entire surface of the leg extending down to the foot had visibly dry, flaking skin present as well with some skin flaking falling off as the pant leg was re-adjusted. R141 stated the "scaling just falls off" lately and he was unsure what, if any, treatment or monitoring was being done adding there was no consistent cream or ointment being applied to his recall. R141 stated the skin was somewhat itchy and sore but added "it's not near as bad as it was [prior]." R141 stated he believed the staff was aware of the condition. When interviewed on 7/17/24 at 9:31 a.m., nursing assistant (NA)-A stated they had worked with R141 prior and described him as "very much independent" with most cares. NA-A stated they	F 684	with appropriate parties and appropriate interventions. - Conduct training sessions for all nursing assistants on the importance of observing skin with all cares, reporting to the licensed staff for appropriate follow-up on any new areas of concern noted and importance of ensuring residents' skin being kept clean and moisturized. 2. **Policy Review and Update:** Review was completed of Skin Integrity Policy and no changes necessary. **Effective implementation of actions will be monitored by:** • The Director of Nursing or designee will audit 10 residents each week on each unit for three months to ensure skin assessment is completed with scheduled weekly bathing, documentation of assessment is completed, any skin impairments are followed-up on appropriately and new interventions, if needed, have been implemented and documented accordingly. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended. **Those Responsible to Maintain Compliance:**	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 684	Continued From page 14 had observed R141's right leg and expressed it had "a black area" on it along with dry skin. NA-A stated they "don't know exactly" how long the dry skin had been present but added, "I think when he came, think so." NA-A verified the dry skin had been present for at least a week to their recall and, as a result, the NA(s) were trying to lotion it when able or if R141 asked for it. NA-A stated the nurses had not directed anything specific for it to their knowledge (i.e., lotion twice a shift) and stated the area appeared "kind of the same" since they had first noticed it prior. NA-A stated the nurses were aware of it to their knowledge adding, "I think so." R141's most recent Comprehensive Skin Risk with Braden, dated 7/14/24, identified R141 needed assistance with activities of daily living (ADLs), had cardiovascular disease and chronic kidney disease (CKD). An attached Braden Scale (used to screen for pressure ulcer risk) identified a score of 16.0 which was labeled, "At Risk." This evaluation identified R141 had bruising present which was not required to be tracked in Wound Management, however, lacked any evidence R141 had dry skin present or what, if any, treatment or monitoring of it was being done despite floor staff knowledge of it. R141's completed Visual Body Inspection(s), dated 6/23/24 to 7/13/24, identified a total of four evaluations were completed. The last completed, on 7/13/24, identified R141 had no skin issues on his heels along with no new skin issues elsewhere with dictation present, "No new skin concerns." Neither of the four completed inspections had any dictation or indication of the developed dry skin condition. In addition, R141's Wound Management tracking, located in the	F 684	• The **Director of Nursing** or designee is responsible for maintaining compliance. **Completion Date for Certification Purposes Only:** • **September 4, 2024** By following these steps, the facility ensures compliance with F684 and promotes the health and well-being of all residents.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 684	Continued From page 15 electronic medical record (EMR), lacked any specific tracking or monitoring of the developed skin condition. R141's medical record was reviewed and lacked evidence the developed skin condition had been comprehensively assessed to determine what, if any, interventions were needed to ensure healing. The record lacked evidence of any current treatments. Further, the record lacked evidence the condition had any ongoing, routine monitoring to ensure healing and prevent complication or worsening. When interviewed on 7/17/24 at 9:38 a.m., registered nurse (RN)-C stated they had just noticed that morning R141 had "dry" skin on his right leg so, as a result, they made a note to contact the medical provider about it and get treatment started. RN-C stated they had noticed R141's right leg yesterday, too, however, didn't feel it was "as much [as bad]" as now adding it looked "so dry." RN-C verified today (7/17/24) was the first time it had been reported to them from the overnight shift. RN-C explained new skin issues or conditions, such as dry skin, should be reported and assessed to determine any treatments needed adding such would be recorded in the progress notes. RN-C verified R141 had no current treatments in place for the dry skin and added, "We should get some orders." On 7/17/24 at 1:59 a.m., registered nurse unit managers (RN)-A and RN-B were interviewed. RN-A verified they had reviewed R141's medical record and explained when a skin condition was identified, then the nurse should evaluate it and update the provider, if needed. RN-A and RN-B	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 684	Continued From page 16 expressed if a NA finds a skin issue, they expected the nurses to be notified. RN-A stated the "wound nurse" had just today looked at R141's leg who applied lotion to what was described as "a lot of that dry, flaky skin." RN-A stated the wound nurse had not been involved with the developed dry skin prior but had just noticed it today when in there observing his skin for other reasons. RN-A explained any evaluation or assessment of a skin condition would likely be under the assessments within the EMR, however, it lacked anything completed. RN-A stated any developed skin condition not improving after a period of treatment should also be re-evaluated and the medical provider updated. RN-A and RN-B both expressed neither of them had been updated on R141's dry skin prior to that day and explained floor staff had various means to update them, if needed, such as e-mail or verbal report. RN-A stated had someone updated them, then it would have been reviewed and evaluated by themselves or the wound nurse sooner. RN-A stated it was important to ensure skin conditions, including dry skin, were evaluated and acted upon timely as "we don't want any further issues [i.e., infection, complication]." A provided Skin Integrity policy, dated 3/2024, identified skin care, the assessment of risk and treatment plans would be based on resident' goals. The policy outlined, "Cassia facilities will use the Wound Management area of the MatrixCare [EMR] to document skin integrity issues." A procedure was listed which included, "NAR will inspect skin daily with cares. Any skin alterations will be reported immediately to licensed nurse," and, "Nurse will communicate new skin alterations to the interdisciplinary team, MD/NP/PA, and the resident representative."	F 684		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 684	Continued From page 17 Further, the policy added, "Nurse will follow documentation guidelines below for any new skin alterations," which included implement appropriate treatment, completion of a new skin risk assessment if pressure or mixed etiology, and update the care plan.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to consistently implement a restorative nursing program (RNP) to prevent a possible decrease in mobility for 1 of 1 residents (R52) reviewed for range of motion. Findings include: R52's quarterly Minimum Data Set (MDS) dated	F 688	**F688: Addressing Deficiency in Restorative Nursing Program (RNP)** **Policy Statement** It is the policy of Cassia Apple Valley Village Health Care Center to comply with the regulation cited under F688. **Plan for Continued Compliance** **Regarding Cited Resident:** It was cited the facility failed to consistently implement a restorative nursing program (RNP) to prevent a possible decrease in mobility for Resident R52, who was reviewed for range of motion. This RNP was reviewed with staff during survey duration and compliance with implementation and documentation of Resident #R52's RNP was resolved prior to survey exit. **Actions Taken to Identify Other Potential Residents Having Similar Occurrences:** • All residents will be assessed for their current range of motion and mobility status to identify any who may require a restorative nursing program (RNP).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 688	Continued From page 18 4/23/24, indicated R52 had intact cognition with no rejection of care behaviors during the look-back period (LBP). The MDS indicated R52 required maximal assistance for transferring, moderate assistance with bed mobility, and walking was not attempted. The MDS indicated R52 received occupational therapy and physical therapy during the LBP but was not on an RNP. R52's care plan dated 7/3/24, indicated R52 was on a RNP and was to receive stand-by assistance (SBA) and verbal cues while ambulating 500 feet daily. R52's orders were reviewed and did not reference an RNP. R52's Point of Care History report dated 7/4/24 through 7/16/24, indicated R52 had completed his RNP twice during the period, 11 times the field was left unanswered, and on one occurrence it was documented as "deferred due to condition". The report did not identify when or if R52 had refused his walking program. R52's medical record was reviewed and lacked indication that R52 had been offered or refused his RNP from 7/4/24 through 7/16/24. R52's physical therapy Discharge Summary dated 6/25/24, indicated on discharge from physical therapy, R52 was ambulating up to 500 feet with SBA and verbal cues. The summary indicated that R52 continued to require assistance with ambulation and was on an RNP. During an interview on 7/15/24 at 3:28 p.m., R52 stated when he was discharged from physical therapy in late June 2024, he was supposed to be	F 688	• Facility Restorative Nursing Policy was reviewed and it was determined that there were no changes necessary. **Measures Put in Place to Ensure Deficient Practice Does Not Recur:** • **Comprehensive Assessment:** Conduct thorough assessments for all residents to determine their need for RNP. • **Personalized RNP Development:** Develop individualized RNPs tailored to each resident's specific needs and goals. • **Staff Training:** Provide extensive training for nursing staff on the importance and implementation of RNPs and their documentation of completion or refusals. • **Dedicated Oversight:** Assign dedicated staff to oversee the consistent application of RNPs. • **Monitoring and Documentation:** Implement a robust system for monitoring and documenting the progress and adherence to RNPs. • **Regular Reviews:** Schedule regular reviews and adjustments of RNPs to ensure their effectiveness. • **Communication:** Maintain open communication with residents and their families regarding the RNPs and their progress. **Effective Implementation of Actions Will Be Monitored By:** - The **Director of Nursing** or designee will audit 10 resident	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 688	Continued From page 19 on a walking program. R52 stated since he had been discharged from physical therapy, he did not recall anyone offering the walking program to him. During an interview on 7/17/24 at 10:05 a.m., physical therapist (PT)-A stated after reviewing R52's medical record, R52 had an RNP that included ambulating 500 feet with SBA daily. PT-A stated it was important this program was completed consistently, so R52 maintained his ability to walk as was established in physical therapy. During an interview on 7/17/24 at 10:14 a.m., nursing assistant (NA)-D stated R52 had "never" refused assistance from him. NA-D stated he was unsure if R52 was on an RNP however thought he might have been receiving assistance with range of motion. During an observation and interview on 7/17/24 at 12:00 p.m., NA-D stated after talking with R52 he thought aides had not been remembering to offer R52 his RNP and was observed instructing R52 to ask staff when he wanted to complete the walking program. During an interview on 7/18/24 at 10:15 a.m., registered nurse (RN)-D, the nurse manager for the unit, stated the RNP would populate as a task the aides had to complete for their documentation so the aides should have been aware of the RNP. The Point of Care History was reviewed with RN-D who confirmed the documentation indicated R52 had not received his RNP consistently and did not include an indication of refusals in the documentation.	F 688	charts per unit monthly for three months to ensure the consistent implementation and documentation of RNPs and adherence to the individualized plans. Results of these audits will be reviewed by the facility QAPI committee, which will decide if further monitoring or audits are recommended. **Those Responsible to Maintain Compliance:** • The **Director of Nursing** or designee is responsible for maintaining compliance. **Completion Date for Certification Purposes Only:** • **September 4, 2024** By implementing these measures, Cassia ensures that the deficiency in the restorative nursing program is addressed and that Resident R52, along with other residents, receives the necessary interventions to maintain and improve their mobility. This comprehensive approach not only rectifies the current issue but also sets a standard for consistent implementation of RNPs for all residents in need.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 688	Continued From page 20 During an interview on 7/18/24 at 11:38 a.m., the director of nursing (DON) stated the instructions for the RNP could be found in the resident's care plan, and documentation of completion was found in the Point of Care History. The DON stated if the restorative nursing program was refused, this would also be documented in the Point of Care History. The facility Restorative Nursing/Functional Maintenance Program Review policy dated 3/28/24, indicated the RNP would have been entered into the care plan and scheduled in the point of care documentation for aides to complete.	F 688		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition	F 690	**F690: Addressing Deficiencies in Indwelling Catheter Use** **Policy Statement** It is the policy of Cassia Apple Valley Village Health Care Center to comply with the regulation cited under F690, which pertains to ensuring appropriate medical justification for the use of indwelling catheters and attempting trial discontinuations without medical justification for continued use. **Plan for Continued Compliance** **Regarding Cited Resident** It is cited that the facility failed to ensure an appropriate medical justification was documented for an indwelling catheter and attempt a trial discontinuation without medical justification for continued use for Resident R35.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 690	Continued From page 21 demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an appropriate medical justification was documented for an indwelling catheter and failed to attempt a trial discontinuation without medical justification for continued use for 1 of 1 resident (R35) reviewed for catheter use. Findings include: R35's quarterly Minimum Data Set (MDS) dated, 6/18/24, indicated R35 was cognitively intact and had an indwelling catheter. R35's Resident Face Sheet, printed 7/17/24, indicated R35 had multiple medical diagnoses including "personal history of urinary (tract) infections" and "other specified disorder of bladder-bladder spasms." R35's physician ordered, dated 7/16/24, instructed staff to "change foley catheter every two weeks and PRN [as needed] for leaking or	F 690	After survey exit, a call was placed to R35's urologist requesting an order for trial void and/or documentation for justification for continued use without trial void. Urology provider and facility continue to coordinate to find next best steps for resident at this time and are working toward a resolution. **Actions Taken to Identify Other Potential Residents Having Similar Occurrences** • All residents with indwelling catheters will be reviewed to ensure that appropriate medical justifications are documented. • A comprehensive audit of all residents' with catheters medical records will be conducted to identify any other instances where trial discontinuations have not been attempted without medical justification. **Measures Put in Place to Ensure Deficient Practice Does Not Recur** • Reviewed facility protocol for documenting medical justifications for indwelling catheters and trial discontinuations, as indicated and ordered, in residents' medical records. • **Staff Training:** Conducted training sessions for all nursing management staff, MDS staff and providers on the importance of documenting medical justifications and the procedures for trial discontinuation of catheters..	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 690	Continued From page 22 decreased urine output with signs of bladder distension. 18 FR [French] 10CC [milliliters]." The order instructed the staff to change the foley catheter once a day on the 2nd and 17th of the month. R35's care plan, revised 7/2/24, indicated R35 required assistance with toileting due to impaired balance/gait and incontinence with a foley catheter in place for urinary output. Interventions included leaving approximately 200 milliliters (ML) of urine in the foley catheter bag when emptying per resident preference. R35's Electronic Medical Record (EMR) lacked medical necessity or justification for the use of a urinary catheter. R35's EMR indicated R35 had two urinary tract infection (UTIs) in the past 6 months. A hospitalization note, dated 1/8/24, indicated R35 was hospitalized due to "nausea, vomiting, diarrhea and pain with urination in her urethra" with a diagnosis of UTI due to Foley catheter and a history of Extended-spectrum beta-lactamases (ESBL) UTI. The hospitalization further indicated R35 had a previous hospitalization in October 2023 with "similar presentation" with a UTI due to Foley catheter. A M Health Fairview Geriatrics provider note, dated 2/16/24, indicated R35 was visited due to concerns regarding increased lethargy and paranoia. The note indicated a urine analysis and culture was collected and came back "grossly abnormal in the setting of indwelling Foley catheter." The note further indicated R35's indwelling foley catheter was placed "years ago	F 690	• Reviewed facility policy for Indwelling Catheter and no changes necessary. **Effective Implementation of Actions Will Be Monitored By** • The **Director of Nursing** or designee will audit 1 chart of residents with indwelling catheters per unit on a weekly basis for three months to ensure that: o Medical justifications for catheter use are properly documented. o Trial discontinuations are attempted when appropriate and documented. • Results of these audits will be reviewed by the facility QAPI committee, which will make the decision if further monitoring/audits are recommended. **Those Responsible to Maintain Compliance** • The **Director of Nursing** or designee is responsible for maintaining compliance with the established protocols and procedures. **Completion Date for Certification Purposes Only** • **Completion Date:** September 4, 2024	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 690	Continued From page 23 due to chronic dysuria [painful urination]" and that R35 historically has not struggled with urine retention. The note further indicated the provider spoke with R35 regarding trialing discontinuation of the Foley catheter and would discuss it further at her regulatory provider visit in March 2024. R35's March 2024 provider visit note lacked any evidence of discussion regarding a trial discontinuation of R35's Foley catheter and indicated, "previously discussed trial without Foley catheter as it was initially placed for dysuria and not obstructive uropathy. Admittedly, did not revisit today." During an interview and observation on 7/15/24 at approximately 5:00 p.m., R35 was laying in bed with a Foley catheter bag hanging at bedside. R35 stated she had the catheter "for years" due to it being painful when she urinated and developing chronic UTIs. R35 did confirm she has had multiple UTIs with the catheter in place. During an interview on 7/18/24 at 11:06 a.m., the nurse manager and registered nurse (RN)-D stated she spoke with the provider who admittedly did not discuss removal of the Foley catheter as she believed R35 would refuse, stating R35 had "adamantly" refused to remove the catheter in the past. RN-D further confirmed that since the catheter was placed in 2021, they had not attempted a trial removal, stating it relieved her symptoms of painful bladder spasms when it was placed. RN-D stated R35 was having some symptoms of dysuria with the catheter in place so it was discussed to potentially remove it however R35 would "not allow it." During an interview on 7/18/24 at approximately	F 690	By implementing these measures, Cassia aims to ensure that all residents with indwelling catheters have appropriate medical justifications documented and that trial discontinuations are attempted when medically feasible. This will improve the quality of care and ensure compliance with regulatory requirements under F690.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 690	Continued From page 24 12:30 p.m., the director of nursing (DON) stated she understood the importance of having medical justification for long standing Foley catheter use and would work with the provider or R35's urologist on proper justification for keeping the Foley catheter in place. A facility policy titled Urinary Indwelling Catheter Insertion and Management, revised 6/25/24, indicated "all residents with an indwelling catheter require a medical justification for the initiation and continuing need for catheter use."	F 690		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to assess and reassess what, if any, non-pharmacological pain interventions would be helpful and accepted by 1 of 1 resident (R95) to supplement medication management of chronic pain continually rated severe and described as frequently interfering with sleep and daily activities. Findings include: R95's quarterly Minimum Data Set (MDS), dated 5/14/24, indicated R95 was cognitively intact with frequent pain rated as 8/10 that frequently affected his sleep and interfered with therapy and	F 697	**F697: Addressing Non-Pharmacological Pain Interventions** **It is the policy of Cassia Apple Valley Village Health Care Center to comply with the F697 regulation cited.** To assure continued compliance, the following plan has been put into place: **Regarding Cited Resident:** It is cited that the facility failed to assess and reassess non-pharmacological pain interventions for Resident R95, who experiences chronic pain that frequently interferes with sleep and daily activities. **Initial Assessment and Reassessment:** - Conducted a comprehensive pain assessment for Resident R95, including pain history, intensity, duration, and impact on daily activities and sleep. - Utilized standardized pain assessment tool.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 697	Continued From page 25 day to day activities. R95's Diagnoses list, dated 5/29/20, indicated R95 had several medical diagnoses including chronic pain syndrome and opioid dependency. R95's physician orders, indicated R95 had the following medication orders; cyclobenzaprine (a muscle relaxer) 10 milligram (mg) one tablet by mouth three times a day (TID), hydrocodone-acetaminophen (a narcotic pain medication used to treat pain) 5-325 mg one tablet by mouth twice a day and two tablets by mouth once a day, Lyrica (used to treat nerve pain) 25 mg two capsules once a day, meloxicam (a nonsteroidal anti-inflammatory drug often used to treat arthritis pain) 15 mg one tablet by mouth TID, Suboxone (contains the opioid buprenorphine, it has some pain-relieving effects and may help chronic pain patients with an opioid use disorder manage their pain as well as their withdrawal symptoms) 8-2 mg one film sublingual (under the tongue) TID. R35's physician orders further indicated an order to monitor pain: "please document signs/symptoms of pain if any and the non-pharms [non-pharmacological] intervention that was used" every shift. R95's pain assessment, dated 5/12/24, indicated R95 received scheduled and as needed pain medications and frequently had pain rated as severe that frequently interfered with sleep and daily activities. The pain assessment indicated via check box that R95 had received non-pharmacological pain interventions however lacked any documentation of what was used or accepted by R95 and what worked or did not in helping decrease R95's pain.	F 697	- Documented reassessment findings in the resident's medical record. **Non-Pharmacological Interventions:** - Collaborated with the interdisciplinary team to identify suitable non-pharmacological pain management strategies for Resident R95. - Offered R95 interventions such as: o Physical Therapy: Resident R95 currently in physical therapy sessions to improve mobility and reduce pain as part of a fall intervention, so encouraged to continue and attend all sessions due to some recent refusals. o Heat/Cold Therapy o Massage Therapy o Relaxation Techniques: Offered to teach Resident R95 relaxation techniques such as deep breathing exercises and guided imagery. o Acupuncture o Music Therapy o Aromatherapy **Monitoring and Documentation:** - Regularly monitored the effectiveness of non-pharmacological interventions through resident feedback and pain reassessment results.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 697		F 697		

Continued From page 26

R95's pain assessment, dated 2/18/24, indicated the same responses as the pain assessment dated 5/12/24, indicating no improvement or change in R95's pain.

R95's medication and treatment administration record indicated R95 had pain rated as 8/10 or higher on 70 shifts (three per day) in the past 30 days.

R95's progress notes, dated 4/1/24 - 7/17/24, were reviewed and lack any evidence of attempted, or offered, non-pharmacological pain interventions to supplement pain medication in an attempt to help relieve R95's chronic pain. R95's progress notes further indicated R95 had five falls on 4/26/24, 5/4/24, 7/7/24, 7/13/24, and 7/17/24.

R95's care plan, dated 6/18/2020, indicated R95 had "actual alteration in COMFORT r/t [related to] OA [osteo arthritis] of (L) [left] knee, morbid obesity, chronic pain. Resident takes scheduled and PRN pain interventions. History of high pain rating, provider aware. Followed by pain clinic." Interventions on R95's care plan had not been revised since 6/18/202 and included "monitor level of comfort and notify provider if pain is not adequately managed with current interventions", "pain medications as ordered" and non-pharmacological interventions: "offer positioning, warm blanket, ice pack, emotional support, toileting, drink, snack, activity, TV show, movie."

R95's electronic medical record (EMR) further lacked a comprehensive assessment and reassessment of what, if any, non-pharmacological pain interventions R95 would accept or were successful in helping to

- Adjusted interventions as needed based on resident response and preferences.
- Thoroughly documented all non-pharmacological interventions provided, including the resident's response and any changes in pain levels.
- Maintained detailed records in the resident's care plan and medical record.

Actions Taken to Identify Other Potential Residents Having Similar Occurrences:

- All residents will be assessed and reassessed for non-pharmacological pain interventions to supplement medication management of chronic pain.

Measures Put in Place to Ensure Deficient Practice Does Not Recur:

- Conducted staff training sessions on assessment of pain utilizing the standardized pain assessment tools, the importance of non-pharmacological pain management, the different options we can offer and proper documentation practices.

Effective Implementation of Actions Will Be Monitored By:

- The **Nursing Team** will audit 10 resident charts weekly per unit for three months to ensure proper assessment and reassessment of non-pharmacological pain

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 697	Continued From page 27 relieve R95's pain despite chronic pain continually rated as severe. R95's pain clinic notes indicated R95 was seen in the pain clinic monthly since 12/6/23. The pain clinic notes indicated no changes to R95's current pain regiment on 12/6/23, 2/7/24, 4/3/24, 5/1/24, and 7/1/24, and lacked any non-pharmacological pain interventions. Medication was adjusted on 1/10/24, and 6/3/24, when Meloxicam was increased. During an interview on 7/17/24 at 8:08 a.m., nursing assistant (NA)-B stated R95 had been having more falls lately because his knees were getting weak and buckling causing him to fall. NA-D stated R95 did not complain of pain to her however she often observed him asking the nurses for pain medication. During an interview on 7/17/24 at 8:26 a.m., R95 was sitting up in his electric wheelchair and stated he continued to have severe pain despite working with the pain clinic. He stated they started him on Suboxone which was supposed to take his pain down but "it doesn't" despite being on it for more than six months. R95 stated his most severe pain was in his knees and tailbone and that he felt a little bit of relief when he could lay in bed to get the weight off of his tailbone. R95 stated his pain was currently a 7/10 and was usually around an eight after being up for the day. R95 further stated he understood he would not be completely pain free but would be comfortable if his pain could decrease to about 4-5/10 and indicated that nobody had assessed what is pain goal was. R95 had his computer open and was currently searching for a new cushion for his wheelchair to see if that would give him any relief. He further	F 697	• interventions. Results of these audits will be reviewed by the facility QAPI committee, and they will make the decision if further monitoring/audits are recommended. **Those Responsible to Maintain Compliance Will Be:** • The **Director of Nursing** or designee is responsible for maintaining compliance. **Completion date for certification purposes only is: September 4, 2024**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 697	Continued From page 28 stated he was open to trying different non-pharmacological pain interventions such as aromatherapy or massage however staff had never asked him what made the pain better or worse or what he was willing to try, stating that staff only asked what his pain level was. R95 indicated he used to ride the stationary bike to try to keep his strength up however the pain in his knees had gotten worse and he could not do it anymore, leading to increased weakness and falls. R95 stated he was going to be starting therapy soon. During an interview on 7/17/24 at 11:04 a.m., registered nurse (RN)-G stated R95 would often report pain however he "does not show pain" and that staff gave him pain medication as ordered and R95 did not have any as needed pain medication to keep it "black and white" since he was "an addict" and would often seek pain medication. RN-G stated in the past, they had tried ice, a warm blanket or offered to lay R95 down however it, "always had to be his pain pills." RN-G stated if a non-pharmacological pain intervention had been attempted, it would have been indicated in a progress note however there was no documentation of what had been attempted, what had worked and what had not worked. During an interview on 7/18/24 at 8:48 a.m., nurse manager and registered nurse (RN)-D stated the pain clinic manages R95's pain and pain medication, stating they got the pain clinic involved in R95's care because he "never backs off of his pain scale" and is always wanting more pain medication. RN-D stated she allowed the nurses to complete their own assessment of R95's pain however his facial expressions did not	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 697	Continued From page 29 match his verbal description of pain. RN-D stated if a non-pharmacological intervention was used it would have been identified in a progress note or a physician order. RN-D stated R95 was "his own worst enemy" and was using the stationary bike however lately, had been refusing to use it, refusing to ambulate and refusing therapy. A facility policy titled Pain Management, revised 10/14/22, indicated "the pain management program was based on a facility-wide commitment to resident comfort. Pain Management could include any of the following measures: assessment, root cause analysis, pharmaceutical and non-pharmaceutical interventions and follow up of effectiveness of PRN pharmaceutical interventions."	F 697		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and	F 791	**F791: Addressing Dental Concerns in Long-Term Care Facility** **Policy Statement** It is the policy of Cassia Apple Valley Village Health Care Center to comply with the regulation cited under F791, ensuring that identified dental concerns are acted upon and referred to the appropriate resource in a timely manner. **Plan for Continued Compliance** **Regarding Cited Residents** It is cited that the facility failed to ensure identified dental concerns (i.e., loose dentures, need for appointment) were acted upon and, if needed, referred to the appropriate resource in a timely manner for 2 of 2 residents (R106, R65) reviewed who voiced dental complaints during the survey.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 791	Continued From page 30 (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure identified dental concerns (i.e., loose dentures, need for appointment) were acted upon and, if needed, referred to the appropriate resource in a timely manner for 2 of 2 residents (R106, R65) reviewed who voiced dental complaints during the survey. Findings include: R106 R106's admission Minimum Data Set (MDS), dated 4/29/24, identified R106 had intact	F 791	During survey period, 2nd floor nurse manager spoke with R65 and her husband, who both declined denture follow-up. Director of Social Services coordinated with R106 and her Community Case Manager due to residents' upcoming discharge to assist in arranging appointments and follow-up with R106's dental, vision and hearing. No changes needed in R106 or R65's diet at this time due to them tolerating current diet with current dentition. **Actions Taken to Identify Other Potential Residents Having Similar Occurrences** • All residents utilizing facility ancillary services dental provider will have their most recent dental visit notes reviewed for dental concerns, including loose dentures and the need for dental appointments or any other necessary follow-up. • Ensure all short stay residents with dental concerns found on initial nutritional evaluation by Registered Dietitian are immediately brought to nursing attention for appropriate follow-up and scheduling with outside provider or in-house ancillary provider. • Ensure all resident dental concerns are documented and reported to appropriate parties for necessary follow-up with outside provider or in-house ancillary provider. **Measures Put in Place to Ensure Deficient Practice Does Not Recur**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 791	Continued From page 31 cognition and demonstrated no delusional thinking. Further, the MDS identified a section labeled, "L0200," along with spaces to record broken/loose-fitting dentures, cavities, or mouth pain. This was answered, "None of the above were present." Further, R106's Census listing, printed 7/18/24, identified R106's current payor source listed, "Medicaid MN," with an effective date, "05/10/2024." On 7/16/24 at 8:33 a.m., R106 was interviewed. R106 stated she admitted to the care center a few months prior and had some "unresolved concerns" with her dentures. R106 explained she used an upper denture which "doesn't fit" along with a bottom plate which had seemingly "shrunk into my gum." R106 stated the misfitting dentures had been an issue for "a long, long time" and, at times, caused trouble chewing for her. R106 stated nobody from the care center had asked her about her dentition or what, if any, dental services or appointments were available or wanted. R106 added the loose dentures had been "really tricky" to deal with lately. R106's Nursing Admission, dated 4/24/24, identified R106 admitted from the hospital on the same date along with a section labeled, "Oral/Dental," which contained spaces to record what, if any, dental concerns were present. This identified R106 had her own teeth on the lower palate along with an upper denture. The assessment, again, marked "None of the above were present," for the various dental conditions as outlined on the MDS. The form lacked any spacing to record what, if any, dental services were explained or offered at the time; nor was there spacing or dictation to record when R106's last dental examination had been.	F 791	• **Immediate Assessment and Documentation**: ○ Implemented a protocol for immediate assessment and documentation of dental concerns voiced by residents. ○ Ensured that all dental concerns are recorded in the residents' medical records promptly. • **Timely Scheduling of Dental Appointments**: ○ Established a system for scheduling dental appointments within 3 days of identifying a dental concern. ○ Coordinated transportation for residents to attend their dental appointments. • **Post-Appointment Follow-Up**: ○ Developed a follow-up procedure to ensure residents' dental concerns are addressed after their appointments. ○ Updated care plans based on the dentist's recommendations and treatment plans. • **Staff Training**: ○ Conducted mandatory training sessions for all nursing staff, dietitians and social service staff on the importance of timely dental care and the referral process. ○ Emphasized the need for prompt action when residents voice dental complaints.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 791	Continued From page 32 However, R106's progress note, dated 4/26/24, identified the following, "NUTRITION: Initial Visit ... Oral/Dental status: Res has upper denture and natural lower teeth. Per [R106], upper denture is poor fitting but easily adjusted w/ [with] denture glue. Res notes some difficulty w/ chewing [due to] poor dentition, however res denies pain/difficulty ... offered foods cut into bite size pieces w/ extra gravy/sauce ... res is agreeable to. Diet order updated accordingly. SLP notified of chewing concerns." The note lacked evidence R106 had been offered any dental appointment to have the dentures evaluated. R106's Care Conference Summary, dated 5/2/24, identified R106's initial care conference was held with R106 in attendance. A section of the summary was labeled, "Ancillary Services offered (Check all that apply," which provided spaces to record what, if any, services were offered including dental. However, this was answered with, "Not applicable (indicate reason) - na." A subsequent section outlined a checkmark placed adjacent to, "Declined all ancillary services." The completed summary lacked evidence which of these conflicting answers (i.e., "NA" versus declined) was accurate; nor if R106's identified loose-fitting denture had been discussed. A subsequent progress note, dated 5/6/24, identified R106 was seen again for a nutritional review and the note outlined, "Res notes some difficulty w/ chewing during initial [staff] visit, which res relates to poor dentition. No chewing/swallowing concerns noted." However, again the note lacked evidence R106 had been offered any dental appointment to have the dentures evaluated.	F 791	• **Policy Review and Update**: o Reviewed the facility's dental care policy and determined no changes necessary. **Effective Implementation of Actions Will Be Monitored By** • The Director of Nursing or designee will audit 10 short stay resident charts monthly for three months to ensure timely assessment, documentation, and referral of dental concerns including offering of on-site dental services, if applicable. • The Director of Nursing or designee will audit 10 resident charts per LTC unit after each on-site dental visit to ensure all recommendations and referrals have appropriate follow-up. • Results of these audits will be reviewed by the facility QAPI committee, which will decide if further monitoring/audits are recommended. **Those Responsible to Maintain Compliance** • The **Director of Nursing** or designee is responsible for maintaining compliance. **Completion Date for Certification Purposes Only** • **September 4, 2024**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 791	Continued From page 33 R106's care plan, last revised 6/27/24, identified R106 required assistance with activities of daily living (ADLs) due to her past medical history and condition. The care plan identified an intervention which read, "ORAL CARE: Staff to provide assist with oral care." However, the care plan lacked any further dictation or interventions for R106's dental status or condition despite R106 being identified to have poor-fitting dental appliances by the nutrition review. When interviewed on 7/16/24 at 1:27 p.m., nursing assistant (NA)-A stated they had worked with R106 a few times since she admitted to the transitional care unit (TCU). NA-A explained R106 needed some help with cares but completed oral cares on her own adding R106 had "her own teeth." NA-A stated they were unaware R106 had complaints of a loose-fitting denture but expressed "last week" they had noticed R106 had a "swollen lip" which they reported to the nurse. NA-A stated they were unsure what caused the swollen lip. Further, NA-A stated any dental appointments would be scheduled through the nurse managers or the health unit coordinators (HUC). R106's medical record was reviewed and lacked evidence the loose-fitting denture had been acted upon and discussed with R106 to determine what, if any, services were wanted or needed; nor if it had been referred to a dental provider despite R106 reporting the denture caused trouble with chewing. On 7/17/24 at 10:00 a.m., registered nurse unit manager (RN)-A was interviewed and verified they had reviewed R106's medical record and	F 791	By implementing these measures, Cassia ensures that dental concerns are managed effectively, improving the quality of care and resident satisfaction.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 791	Continued From page 34 spoken to the social worker (SW) about R106's dental status. RN-A explained when a resident admitted to the TCU, they were typically there for only a "short time" so it was difficult to get them referred to the in-house service for dental needs as they were onsite only quarterly. However, RN-A stated if concerns were expressed by the resident or identified, they could get a referral sent and arrange an outside appointment, if needed. RN-A stated the nurses who evaluated a resident's dentition could also notify them or social services if concerns were identified. RN-A stated neither them or the social worker were aware R106 had a loose-fitting denture (as identified in the progress notes) and verified the dietary staff who authored the notes had not passed the information onto them. RN-A stated if they had been told of it, then a referral would have been placed and help provided to R106 to set-up a dental appointment with an outside service. RN-A stated the author of the note had verbally reported (just prior when asked about it due to surveyor inquiry) R106 stated she did not want any action taken with it, however, RN-A acknowledged the lack of documentation in the medical record to support such adding, "I would have documented that personally." RN-A verified R106's medical record lacked evidence the loose-fitting denture was acted upon to determine what, if any, services were wanted or needed adding, "No, not that I see." RN-A reviewed R106's Care Conference Summary and acknowledged the recorded response of 'NA' under ancillary services. RN-A stated the social worker, to her recall, did not routinely offer dental appointments or referrals at the time of these conferences to TCU-based residents. Further, RN-A stated it was important to ensure dental issues, such as loose-fitting dentures, were acted	F 791		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 791	Continued From page 35 upon timely to ensure no oral discomfort and proper nutrition was maintained. R65 R65's significant change MDS assessment, dated 5/22/24, indicated R65 had intact cognition and demonstrated no delusional thinking. Further, the MDS identified a section labeled, "L0200," along with spaces to record no natural teeth or tooth fragments(s) (edentulous). This was answered, "None of the above were present." Further, R65's Face Sheet, printed 7/18/24, identified R65's current payor source listed as, "Medicaid MN." On 7/16/24 at 8:32 a.m., R65 was interviewed and stated, "I don't have any dentures ...I would like dentures." R65 explained "they haven't talked to me about dentures." R65 further clarified that nursing staff or social workers at the facility have not talked to her about dentures and indicated she has not had dentures since being in the facility. R65's Chart Progress Note dental visit, dated 2/27/24, indicated R65 was seen for dental exam and expressed interest in dentures. Note indicated, "We discussed the options of traditional dentures vs implant supported dentures vs no treatment .... She states she is interested in plant supported dentures." Note further indicated, "We have referred [R65] to our Mounds View office for a consult re: [regarding] implant supported dentures." R65's Care Conference Summary, dated 3/14/24, indicated a quarterly care conference was completed and a radio-button answered "yes" to R65, and family invited and attended care	F 791		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 791	Continued From page 36 conference. Under ancillary services section, indicate approximate date of last visit- Last dental visit date, indicated "see resident documents." The document lacked any information about dentures or follow up on dental visit from 2/24. R65's Care Conference Summary, dated 6/2/24, indicated a quarterly care conference was completed and a radio-button answered "yes" to R65, and family invited and attended care conference. Under ancillary services section, indicate approximate date of last visit. Last dental visit date, indicated "see resident documents." The document lacked any information about dentures or follow up on dental visit from 2/24. A review of R65's progress notes, dated 1/2/24 to 7/17/24, lacked evidence of reference to dental appointment in February 2024. On 7/17/24, a progress note indicated, "in discussion with resident and resident's spouse, resident and spouse endorsed together that they do not wish to pursue dentures/implants at this time." This was after surveyor inquired about status of dentures and appointment follow up for R65. R65's care plan, printed 7/16/23, identified R65 required assistance with activities of daily living. The care plan identified an intervention which read, "ORAL CARE: Staff to provide assist with oral care." However, the care plan lacked any further dictation or interventions for R65's dental status or condition. R65's medical record was reviewed and lacked evidence of coordination after dental appointment and R65's desire to obtain dentures.	F 791		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 791	Continued From page 37 On 7/17/24 at 2:20 p.m., registered nurse unit manager (RN)-F indicated the process for getting a resident seen for dental is social services obtains the consent signed, which is then sent to the dental provider. They [dental provider] determined who they were going to see at the visits and came every couple of months. RN-F stated if there is an urgent need or concern, "they can be seen sooner." After reviewing documentation, RN-F indicated that "it looks like [R65] was referred to another dental clinic" which they were going to follow up with. On 7/18/24 at 8:10 a.m., RN-F indicated they had a conversation with [R65] and her husband about dentures, "they only want implants," and did not want to go back and forth with appointments and have decided to not proceed. RN-F stated that this was an elective procedure for R65. RN-F stated the current process for paperwork received from onsite dental visits was the paperwork was sent to the facility, given to the nurse manager on the floor who reviewed, completed follow up as indicated and then placed in the chart. RN-F indicated this has been the process since they had been there and added, "I was not employed here when she was seen by the dentist." R65 verified there was no progress notes in R65 regarding follow up appointments for dental appointments. On 7/18/24 at 10:08 a.m., RN-F indicated they followed up with onsite dental provider and was informed that an appointment was made for R65 at the other clinic after the referral was made, the care coordinator (at the dental provider) was unable to provide information as to who was notified about the appointment.	F 791		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 791	Continued From page 38 On 7/18/24 at 10:25 a.m., family member (FM)-C indicated that they are involved with R65's care and visit often. FM-C confirmed the facility had not talked to them until yesterday (7/17) about R65's desire for dentures. FM-C indicated R65 had talked about wanting dentures around the beginning of the year. On 7/18/24 at 11:11 a.m., director of nursing (DON) stated they had a dental provider that provided onsite services routinely. She stated social services obtained consents and the dental visit notes were uploaded into the chart. DON further indicated the facility was not notified of R65's referral appointment being made as an order would have been entered with a time and date and there was no order for it. The facility was unable to provide any documentation to support that facility was involved or aware of follow up needed from February dental appointment prior to survey. A facility policy titled Ancillary Services, reviewed 2/12/24, was provided. The document indicated social services staff or designee would meet with resident or their representative upon admission and identify needs and goals for obtaining care from Ancillary service providers and then obtain information from the last dental visit. Further indicated health information staff or designee with schedule appropriate appointment per facility procedures and social service staff or designee would document the resident's plan for ancillary health care services in resident's care conference summary form. Ancillary services were reviewed with each care conference and updated when requested by resident/resident representative.	F 791		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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

APPROVED
By Travis Z. Ahrens at 12:04 pm, Aug 07, 2024

Travis Z. Ahrens 49207

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

PRINTED: 07/25/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING **01** B. WING _____	**07/16/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	**14650 GARRETT AVENUE** **APPLE VALLEY, MN 55124**

(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 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on July 16, 2024, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Apple Valley Village Health Care 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) 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 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

David Shaw — Administrator — 8-7-24

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING **01** B. WING _____	**07/16/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	**14650 GARRETT AVENUE** **APPLE VALLEY, MN 55124**

(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 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email 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. Building Information: AUGUSTANA HEALTHCARE CENTER OF APPLE VALLEY is a three-story building, with a full basement The building was constructed in 1983 and was determined to be of Type II (222) construction, with a full basement. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING **01** B. WING _____	**07/16/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	**14650 GARRETT AVENUE** **APPLE VALLEY, MN 55124**

(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 000	Continued From page 2 full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 164 beds and had a census of 121 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain an egress corridors and emergency egress door per NFPA 101 (2012 edition), Life Safety Code, section 7.7.3.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/16/2024, between 8:00 AM and 10:00 AM, it was revealed by observation that the main stair has a gate that prevents persons from traveling below the level of discharge that would not close.	K 211	K-211 It is the policy of Apple Valley Village HealthCare Center to comply with the standards of egress. Corrective Action: The offending gate has been replaced with an appropriate gate to impede movement of occupants away the safety of the fire exit door. The remaining gates have been tested and adjustments made. Responsible Person: the Director of Maintenance Date: 7/31/2024 Identification of Other Residents: Non-compliance with egress standards has possible impacts on residents in case of an emergency. Replacement of the gate is one tool to ensure all will have a clear path to safety. Measures Put in Place Replacement of the deficient gate and attention placed to all gates will ensure that we adhere to NFPA 101, when it comes to egress. Monitoring Mechanism Maintenance staff are told of the importance and reasoning for the gates, they will report/repair issues during their daily work travels. Responsible Party: the Director of Maintenance Date: 7/31/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING **01** B. WING _____	**07/16/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	**14650 GARRETT AVENUE APPLE VALLEY, MN 55124**

(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 211	Continued From page 3 An interview with the Director of Facilities verified this deficient findings at the time of discovery.	K 211	K-351 It is the policy of Apple Valley Village HCC to comply with the standards pertaining to sprinklers contained in NFPA 101	
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install sprinkler heads per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1 and 9.7.1.1 and NFPA 13 (2010 edition), The Standard for the Installation of Sprinkler Systems, sections 8.1.1, 8.3.2.5, 8.4.9.1 and 8.4.9.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 351	Corrective Action: An audit will be done by staff to find wire in contact with sprinklers and sprinkler lines, our findings will be documented and corrected. Furthermore, we will make a flyer to give to outside contractors, reminding them of the importance of adhering to standards set forth by the NFPA regarding sprinklers and smoke barriers. Responsible Person: the Director of Maintenance Completion Date: 10/15/24 Identification of Other Residents: Non-compliance with sprinkler standards has a potential of wide-spread impact on residents of this facility. Removing wires that bear on sprinkler pipes addresses and mitigates issues associated with non-compliance NFPA 13 Measures Put in Place An audit sheet will be created so that all areas of the building will be assessed for infractions associated with sprinklers. Monitoring Mechanism After the audit of the building, we will work with our contracted parties to ensure they are adhering to the standard of NFPA 101 Responsible Party: the Director of Maintenance Date: 7/31/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING **01** B. WING _____	**07/16/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	**14650 GARRETT AVENUE APPLE VALLEY, MN 55124**

(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 351	Continued From page 4 On 07/16/2024, between 8:00 AM and 10:00 AM, it was revealed by observation that there were wires in contact with the sprinkler pipe above the ceiling near the 3rd floor Nurses Station. An interview with the Director of Facilities verified this deficient findings at the time of discovery.	K 351	K-353 It is the policy of Apple Valley Village HCC to keep spacing of stored items 18" away from stored/ combustible items in accordance with NFPA 101 Life safety code. Corrective Action: The cabinet, made of combustible material, was moved several feet away to a location not in line with the sprinkler head. Responsible Person: the Director of Maintenance Date 7/31/24 Identification of Other Residents: Non-compliance with the standard could have a widespread impact on residents within the facility Measures Put in Place: The cabinet was moved away from the sprinkler head and other storage areas were inspected to ensure there were no other obstructions. Signage saying "no storage above this point" were hung in all storage areas indicating 18" below the lowest sprinkler head. Monitoring Mechanism: An audit will be done twice a year, ensuring that nothing is being stored above a certain level. The audits will be scheduled on our maintenance scheduling program. Responsible Person: the Director of Maintenance Date 7/31/24	
K 353 SS=F	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. 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 REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection,	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING **01** B. WING _____	**07/16/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	**14650 GARRETT AVENUE APPLE VALLEY, MN 55124**

(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 353	Continued From page 5 Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. This deficient finding could a widespread impact on the residents within the facility. Findings include: On 07/16/2024, between 8:00 AM and 10:00 AM, it was revealed by observation that in the storage room #S-323, items were being stored within 18" of the automatic sprinkler system. An interview with the Director of Facilities verified this deficient findings at the time of discovery.	K 353		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code,	K 712	K-712 It is the policy of Apple Valley Village HCC to hold fire drills according to NFPA 101. The drills should be conducted monthly rotating the shift, varying both the time and date. Corrective Action: Missing documentation has been rounded up and organized. Moving forward, a scheduling grid will be used varying date, shift and time by 90 minutes. Responsible Person: the Director of Maintenance Date: 7/31/24 Identification of Other Residents: Properly documenting Fire Drills has minimal impact on the residents of AVVHCC. Not conducting fire drills can have a wide spread impact on our residents. Measures Put in Place: A scheduling grid has been made varying time, date, and shift. A binder will be created, just for fire drills in hopes of better organizing my paperwork associated with fire drills. Monitoring Mechanism: Documents will be presented to the safety committee at their monthly meetings, ensuring that I am following the scheduling grid and including proper documentation. Responsible Party: the Director of Maintenance Date: 7/31/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING **01** B. WING _____	**07/16/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	**14650 GARRETT AVENUE APPLE VALLEY, MN 55124**

(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 712	Continued From page 6 sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/16/2024, between 8:00 AM and 10:00 AM, it was revealed by a review of available documentation that fire drills were not being documented properly to show evidence of all elements being tested. Adequate documentation could only be provided for 4 of the required 12 fire drills. An interview with the Director of Facilities verified this deficient finding at the time of discovery.	K 712		
K 926 SS=F	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement medical gas training for staff per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.5.2.1.1, 11.5.2.1.4. This deficient finding could have a widespread impact on the residents within the facility.	K 926		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING **01** B. WING _____	**07/16/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY VILLAGE HEALTH CARE CENTER	**14650 GARRETT AVENUE APPLE VALLEY, MN 55124**

(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 926	Continued From page 7 Findings include: On 07/16/2024, between 8:00 AM and 10:00 AM, it was revealed by observations that none of the oxygen filling rooms for, had the necessary PPE for staff protection. An interview with the Director of Facilities verified this deficient finding at the time of discovery.	K 926	K-926 It is the policy of Apple Valley Village Health Care Center to provide med gas training and to provide appropriate PPE for the handling and transfer of oxygen in the transfer rooms. Corrective Action: All necessary PPE has been purchased and placed in all three of our oxygen storage and transfer rooms. The PPE provided: special gloves, face shields, eye protection and ear protection. Responsible Person: the Director of Maintenance Date: 7/31/24 Identification of Other Residents: Non-compliance with proper med gas training has potential wide-spread impact on residents within the facility. Not having PPE has very limited impact to our residents. Measures Put in Place: PPE has been placed in the O2 rooms Monitoring Mechanism: We will post a sign above the PPE storage stating "Please Notify Maintenance if PPE Needs Replacing" Responsible Person: the Director of Maintenance Date 7/31/24	