*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
April 30, 2025

Administrator
Valley Care And Rehab LLC
600 Fifth Street Southeast, Box 129
Barnesville, MN  56514

RE: CCN: 245281
Cycle Start Date: April 23, 2025

Dear Administrator:

On April 23, 2025, 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:

**LeAnn Huseth, RN, Regional Operations Supervisor**
**Fergus Falls District Office**
**Health Regulation Division**
**Minnesota Department of Health**
**2312 College Way**
**Fergus Falls, MN 56537**
**Email: leann.huseth@state.mn.us**
**Office: (218) 332-5140 Mobile: (218) 403-1100**

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by July 23, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 23, 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)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

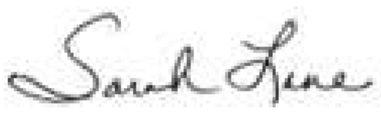
A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process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

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

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

Feel free to contact me if you have questions.

Sincerely,



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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245281 | A. BUILDING _____ B. WING _____ | 04/23/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VALLEY CARE AND REHAB LLC | 600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514 |

| (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 |
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| E 000 | Initial Comments<br><br>On 4/21/25 to 4/23/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance.<br><br>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<br><br>On 4/21/25 to 4/23/25, 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 NOT in compliance.<br><br>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.<br><br>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 812 SS=E | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) | F 812 | | 5/6/25 |

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

Electronically Signed | 05/09/2025

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

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| F 812 | Continued From page 1<br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, food items were not served in a sanitary and clean manner to residents observed during meals served from the steamer table in the kitchen. This deficient practice had the potential to affect all 10 residents who were served bread during their meal.<br><br>Findings include:<br><br>During an observation on 4/21/25 at 12:14 p.m. ,dietary manager (DM)-A removed the saran wrap over the cold items, and covers over other items in the steam table after washing hands and applying gloves. DM-A placed the resident meal choice slips of paper which were approximately three by three inches onto the metal counter area in the front of the steam table with gloved hands. | F 812 | F812 Food Procurement, Store/Prepare/Serve Sanitary<br>The facility failed to ensure food was served in a sanitary and clean manner to residents observed during meals served from the steamer table in the kitchen.<br>Please accept the following as the facilitys plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.<br>" Plan for correcting the specific deficiency addressing the process that led to the deficiency<br>Policy and procedures for Food Procurement, Store/Prepare/Serve Sanitary reviewed and found to be | |

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| F 812 | Continued From page 2<br>DM-A began to set up a plate of taco salad which she used utensils to place the lettuce, tomatoes, cheese and taco meat and chips onto the plate. DM-A picked up a piece of bread with her right hand, held it in her left hand while buttering the bread, and placed it onto the plate. DM-A proceeded to dish up other plates of food with either the chicken Kiev meal, or the taco salad. Not all plates included the buttered bread slice. DM-A continued to touch the meal choice slips, with one or both hands, moving them around, turning them over and continued to pick up bread slices and butter them without changing her gloves after touching the meal choice slips. DM-A indicated meal choice slips were filled out by the residents, nursing assistants or activity staff during the lunch the day before. At 12:18 p.m. DM-A took two slices of bread with her left gloved hand over to the toaster, used both gloved hands and put the bread in the toaster. DM-A removed the gloves and applied new gloves. DM-A went back to the steam table, touched multiple meal choice slips, and began to dish up more meals. DM-A moved the slips around again, removed gloves, applied new gloves, went to the toaster and removed the toast from the toaster with gloved hands, applied peanut butter to the toast, and went back to the steam table to finish dishing up that meal. DM-A removed gloves and applied new gloves and began to touch and move around the meal slips and dished up other meals. DM-A indicated not all residents received the bread and picked up a meal choice slip to show surveyor. On the meal slip the word bread was circled. DM-A indicated those residents would be served bread. DM-A proceeded to pick up bread slices and butter them with her gloved hands, after touching the meal choice slips. | F 812 | compliant with the regulation.<br>All dietary staff received immediate verbal education from the Dietary Manager about food preparation and serving, glove use, cross-contamination, and hand hygiene. Written education about facility policies and procedures related to the preparation and serving of food, glove use, and hand hygiene was provided.<br>Annual training assigned to all dietary staff through Healthcare Academys Safe Food Handling module.<br>" Procedure for implementing the plan<br>All residents receiving a meal have the potential to be affected. Care plans, dietary serving cards, and dietary preferences have been audited and updated as needed.<br>Resident choice slips will continue to be displayed on the counter for the cook to verify meal items to be served. Slips will be set up in a manner that will allow visualization of the slip without contact. As able, all food will be prepared in advance and will be served with the appropriate serving utensil. Hand hygiene will be performed before donning gloves and with every glove change. Gloves are considered a food contact surface and must be changed any time gloves are in contact with items other than food.<br>Visual aids are added to food preparation area as a reference to hand hygiene moments and glove use.<br>" Monitoring procedure to ensure plan is effective & that the deficiency remains corrected & compliant. Title of the person responsible for implementing the plan of correction | |

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| F 812 | Continued From page 3<br>During an interview on 4/22/25 at 10:56 a.m., DM-A stated their usual process for serving foods, was not to touch the foods with hands and were expected to use utensils. DM-A stated if they walked away from the steam table they changed their gloves. DM-A confirmed she had touched the meal choice slips with gloved hands and touched the bread without changing gloves between. DM-A indicated she had felt flustered yesterday during the observation. DM-A indicated her usual process was to have all bread buttered and to use tongs to put onto plates. DM-A stated she would usually have all the meal choice slips laid out so she could read them and confirmed yesterday during the observation it had not been done that way. DM-A stated it was important not to touch foods with gloved hands after touching the slips to prevent cross contamination and stated the slips were considered dirty.<br><br>Review of facility policy titled Food Procurement, Store/Prepare/Serve-Sanitary revised 3/5/24, identified the facility would ensure they followed sanitation and food handling practices, and ensured food safety was maintained during buffet style or steam table food serving opportunities. The policy identified gloved hands were considered a food contact surface that could become contaminated or soiled. The policy identified failure to change gloves and wash hands between tasks, including handling ready to eat foods, could contribute to cross-contamination. Cross contamination could occur between harmful substances or disease-causing microorganism transferred to food by hands, including gloved hands. Food would be handled with new clean gloves, clean equipment and utensils. | F 812 | The dietary manager will audit food preparation and serving for all meals x 1 week, then one meal daily x3 weeks, and then a random meal weekly x8 weeks to observe preparation and serving of food as well as hand hygiene. In-service training records and observational audit results to be reported to QAPI committee to review and ensure effectiveness and sustained compliance.<br><br>" Date the facility will be in complete compliance<br>Corrective actions completed by May 6, 2025. | |

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| | 245281 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **04/22/2025** |

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/22/2025. At the time of this survey, Valley Care And Rehab Llc 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.<br><br>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.<br><br>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.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:<br><br>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

Electronically Signed | 05/09/2025

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

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| K 000 | Continued From page 1<br>Healthcare Fire Inspections<br>State Fire Marshal Division<br>445 Minnesota St., Suite 145<br>St. Paul, MN 55101-5145, OR<br><br>By email to:<br>FM.HC.Inspections@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A detailed description of the corrective action taken or planned to correct the deficiency.<br><br>2. Address the measures that will be put in place to ensure the deficiency does not reoccur.<br><br>3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.<br><br>4. Identify who is responsible for the corrective actions and monitoring of compliance.<br><br>5. The actual or proposed date for completion of the remedy.<br><br>Valley Care & Rehab is a 1-story building with no basement. The building was constructed at three different times. The original building was constructed in 1963 and was determined to be of Type II(000) construction. In 1980, a Sun Room addition was added to the south of the Dining Room/Day Room that was determined to be of Type V(000) construction. In 1994 an addition to the main entrance to the west was constructed and was determined to be of Type II(111) construction. | K 000 | | |

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| K 000 | Continued From page 2<br><br>The building is completely protected by an automatic fire sprinkler system installed and also has a fire alarm system with smoke detection in the corridors and areas open to the corridors that is monitored for automatic fire department notification.<br><br>The facility has a capacity of 35 beds and had a census of 27 at the time of the survey.<br><br>The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by: | K 000 | | |
| K 363<br>SS=F | Corridor - Doors<br>CFR(s): NFPA 101<br><br>Corridor - Doors<br>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or | K 363 | | 4/29/25 |

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| K 363 | Continued From page 3<br>pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.<br><br>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485<br>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have an isolated impact on the residents within the facility.<br><br>Findings include:<br><br>On 04/22/2025 between 10:30am and 1:30pm, it was revealed by observation that the several of the resident room doors did not latch when tested.<br><br>An interview with the Maintenance Director and Facility Administrator verified this deficient finding at the time of discovery. | K 363 | K363 Corridor -Doors<br>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.<br>1. It should be noted that all doors tested on 04/22/25 did latch; however, 3 doors required more effort than others. All corridor doors were re-inspected and tested for proper operation on 04/22/25 and adjusted as needed.<br>2. On 04/29/25 all staff were educated about corridor door Life Safety Codes, and the importance of each door should latch, and they are to report any concerns to the maintenance director immediately.<br>3. The facility completed the annual door inspected on 03/05/2025. Per regulations, the facility will continue to complete, at | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245281 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **04/22/2025** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **VALLEY CARE AND REHAB LLC** | **600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514** |

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|---|---|---|---|---|
| K 363 | Continued From page 4 | K 363 | minimum, annual door inspections, testing, and maintenance of all smoke resisting doors in the facility. These inspections/audits will be completed by the Maintenance Director.<br>4. Date of compliance 04/29/2025 | |
| K 712<br>SS=F | Fire Drills<br>CFR(s): NFPA 101<br><br>Fire Drills<br>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.<br>19.7.1.4 through 19.7.1.7<br>This REQUIREMENT is not met as evidenced by:<br>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, 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.<br><br>Findings include:<br><br>On 04/22/2025 between 10:30am and 1:30pm, it was revealed by a review of available documentation that fire drills did not meet the varying time requirement: first shift 04/30/2024 at 10:37am, 07/23/2024 at 10:54am, and | K 712 | K712 Fire Drill<br>1. It should be noted that the facility is compliant with the frequency of fire drills completed on an annual basis. All future fire drills will be conducted at varying times and conditions.<br>2. On 04/22/2025, the Maintenance Director was educated on the requirements related to varying times and conditions in which fire drills should be spaced.<br>3. The facility policy and procedure were reviewed and updated as needed. The Maintenance Directors reviewed all upcoming fire drills and adjusted times | 4/22/25 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245281 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **04/22/2025** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| K 712 | Continued From page 5<br>10/30/2024 at 11:04am. second shift 08/29/2024 at 4:45pm and 11/29/2024 at 5:00pm. These drills do not meet the requirement of varying times.<br><br>An interview with the Maintenance Director and Facility Administrator verified this deficient finding at the time of discovery. | K 712 | and conditions to comply with regulation.<br>4. The Maintenance Director will continue to oversee all fire drills. The Administrator will audit fire drill times and conditions for the next three months to ensure compliance.<br>5. Date of compliance 04/22/2025 | |

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered
May 28, 2025

Administrator
Valley Care And Rehab LLC
600 Fifth Street Southeast, Box 129
Barnesville, MN  56514

RE: CCN: 245281
Cycle Start Date: April 23, 2025

Dear Administrator:

On May 20, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance.  Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

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