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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 2GV9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00750

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/04/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Jennifer Lageson, HFE NE II 07/15/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/14/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 08/27/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245423

August 18, 2014

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

Dear Mr. Backen:

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

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

Effective August 11, 2014 the above facility is certified for or recommended for:

78 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 18, 2014

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

RE: Project Number S5423024 and Compliant H5423014

Dear Mr. Backen:

On July 9, 2014, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective August 16, 2014. (42 CFR 488.417 (b))

Also, we notified you in our letter of July 9, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 16, 2014.

This was based on the deficiencies cited by the Minnesota Department of Health, Office of Health Facility Complaints for an abbreviated standard survey completed on May 16, 2014 and the survey completed by the Minnesota Department of Health on June 26, 2014, and lack of verification of substantial compliance with the Life Safety Code (LSC) deficiencies at the time of our July 9, 2014 notice.

On August 4, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 16, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 1, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 16, 2014, as of August 11, 2014.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of July 9, 2014. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective August 16, 2014, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective August 16, 2014, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective August 16, 2014, is to be rescinded.

In our letter of July 9, 2014, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 16, 2014, due to denial of payment for new admissions. Since your facility attained substantial compliance on August 11, 2014, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245423	A. Building B. Wing	8/4/2014

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **08/01/2014**	ID Prefix **F0247** Reg. # **483.15(e)(2)** LSC	Correction Completed **08/01/2014**	ID Prefix **F0250** Reg. # **483.15(g)(1)** LSC	Correction Completed **08/01/2014**
ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **08/01/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **08/01/2014**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **08/01/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GN/KFD	08/18/2014	10155	08/04/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
6/26/2014			

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245423	01 - MAIN BUILDING 01	8/12/2014

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0144	08/11/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/KFD	Date: 08/18/2014	Signature of Surveyor: 25822	Date: 08/12/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 6/23/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

August 18, 2014

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

Re: Reinspection Results - Project Number S5423024

Dear Mr. Backen:

On August 12, 2014 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 26, 2014, that included an investigation of complaint number H5423014. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00750	A. Building B. Wing	8/4/2014

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

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20435** Reg. # **MN Rule 4658.0210 Subp.** LSC	Correction Completed **08/01/2014**	ID Prefix **20860** Reg. # **MN Rule 4658.0520 Subp.** LSC	Correction Completed **08/01/2014**	ID Prefix **21426** Reg. # **MN St. Statute 144A.04 Su** LSC	Correction Completed **08/01/2014**
ID Prefix **21495** Reg. # **MN Rule 4658.1005 Subp.** LSC	Correction Completed **08/01/2014**	ID Prefix **21665** Reg. # **MN Rule 4658.1400** LSC	Correction Completed **08/01/2014**	ID Prefix **21695** Reg. # **MN Rule 4658.1415 Subp.** LSC	Correction Completed **08/01/2014**
ID Prefix **21805** Reg. # **MN St. Statute 144.651 Sul** LSC	Correction Completed **08/01/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GN/KFD	08/18/2014	10155	08/04/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
6/26/2014				

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 2GV9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00750

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/26/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Kyla Einertson, HFE NE II 07/15/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/14/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 08/19/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
July 9, 2014

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

RE: Project Number S5423024

Dear Mr. Backen:

On May 23, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an abbreviated survey, completed on May 16, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On June 26, 2014, the Minnesota Department of Health and on June 23, 2014, the Minnesota Department of Public Safety completed a standard survey 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 the facility to widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS 2567) is enclosed.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective August 16, 2014. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective August 16, 2014. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 16, 2014. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Chosen Valley Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective August 16, 2014. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

DEPARTMENT CONTACT

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

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Telephone: (507) 206-2731
Fax: (507) 206-2711

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

- Include electronic acknowledgement signature of provider and date.

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 remedy be imposed:

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 16, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:

http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING _____ B. WING _____	06/26/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dignity was promoted for 1 of 1 resident (R7) who had to wait 21 minutes for help even though there was staff in the area who ignored his request for assistance. Findings include: R7's computer generated care plan dated 1/27/14; identified R7 had been admitted on 1/13/14, with diagnosis that included impaired cognition and hemiplegia secondary to right	F 241	This plan and response to CMS-2567 regarding Tag F 241, is written solely to maintain certification in the Medicare and Medical Assistance programs. We wish to preserve our right to dispute these findings in their entirely should any remedies be imposed. The policies and procedures for Dignity and Answering Call lights has been reviewed and found appropriate. After it was known that resident (R7) had	8/1/14

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

Electronically Signed | 07/15/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING _____ B. WING _____	06/26/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 1 cerebral vascular accident (CVA.) The care plan noted R7 had impaired mobility and required staff assist to dress, move in wheel chair and change position. The care plan also identified R7 had the potential to fall related to hemiplegia (paralysis of one side of the body), was incontinent of bowel and bladder and directed staff to remind R7 to call for assist before attempting to transfer self. The care plan further indicated R7 required assist to toilet and read, "I don't like to ask for help." R7's quarterly Minimum Data Set (MDS) dated 4/13/14 indicated R7 had impaired cognition, had difficulty hearing in some environments such as a noisy setting, did not use hearing aids, and had difficulty communicating to others. On 6/25/14, at 9:30 a.m. R7 had been observed sitting in a wheel chair in the east hall common area, in front of a television (TV) which displayed a sports program. R7 was wearing a long sleeve shirt, unbuttoned at the sleeves which caused the sleeves to hang off the arm from the elbow down. Four other residents were noted sitting in front of the TV. Licensed practical nurse (LPN)-A observed sitting at the nurse ' s desk typing on a computer, and housekeeping staff observed in the area with cleaning equipment, entering and exiting resident rooms. Between 10:09 a.m. and 10:30 a.m. a total of 21 minutes. R7 was observed to call out for assistance with no intervention from staff in the area. At 10:30 a.m. the nursing assistant (NA) supervisor approached R7 and asked what was needed. R7 stated that he wanted to get up. At 10:37 a.m. two NA's took R7 to his room, at that time R7 requested staff to button the shirt sleeves and to be toileted. On 6/25/14, at 1:26 p.m. LPN-A verified she had	F 241	waited an extended period of time for assistance, Call light wait time report was reviewed. Care plan was reviewed with resident□s spouse and has been updated in regards to resident□s preferred time to get up in the morning and time to go to bed in the evening. All residents who residents who reside at Chosen Valley Care Center have the potential to be affected by this deficient practice. Nursing Assistants, Nurses and TMAs have initially been notified in shift report of expectation of all request for assistance be responded to in a timely manner starting on 6/27/14. All licensed and unlicensed staff will be re-educated on resident dignity and answering call lights on July 17th, 18th and 21ST 2014. The Director of Nursing/designee will complete a Requested Assistance Wait Time Monitor that was developed to ensure that residents received assistance within an appropriate amount of time. The monitor will be completed for 30 days and randomly thereafter. If noncompliance is noted, additional auditing and staff training will be done. Results from monitors will be reviewed at QAPI Steering Committee meeting for 3 months and at Quarterly Quality Improvement meeting for one full year.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING _____ B. WING _____	06/26/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 2 heard R7 call for help and stated she had not assisted R7 because she was documenting a verbal telephone order and wanted to finish that before she forgot. The housekeeper who was in the area of R7 calling for help was unavailable for interview. On 6/25/14, at 1:50 p.m. the director of nursing verified staff had not addressed R7's call for help timely and stated staff should have went to him and asked him what he needed at the time he first called out for help. On 6/26/14, at 9:11 a.m. licensed social worker (LSW)-A verified R7 had not been treated in a dignified manner then LSW-A stated "That's not ok" in regards to not asking R7 what he needed when first called for help. Quality of Life-Dignity policy revised 10/09, was reviewed and noted each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Interpretation and implementation #11 included demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed by: a. Promptly responding to the residents' request for toileting assistance.	F 241		
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced	F 247		8/1/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING _____ B. WING _____	06/26/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 247	Continued From page 3 by: Based on interview and document review, the facility failed to provide notice for change of roommate assignments, prior to the change occurring for 1 of 2 residents (R94) who had a recent room change. Findings include: R94 reported a new roommate had moved in within the last couple of weeks without prior notification from the facility during interview on 6/24/14 at 11:24 a.m. R94 indicated that roommates come and go and he knows when they're coming in when they start bringing in things for the resident. However, the staff doesn ' t inform R94 before the roommate moves into the room. Review of R94 ' s record lacked documentation that notification for the roommate change had been provided for the most recent roommate. R94's quarterly Minimum Data Set (MDS) dated 4/20/14 indicated that the resident had intact cognition with a Brief Interview for Mental Status (BIMS) score of 15. During an interview on 6/25/14 at 7:25 a.m., registered nurse, (RN)-B, indicated that she was unable to find any documentation that R94 was notified of his new roommate. RN-B verified that R94 did receive a new roommate recently during the past month. A policy titled Transfer, Room to Room, dated 12/2012, indicated that a roommate will be informed of any new transfer into his/her room. Such information will include why the transfer is	F 247	This plan and response to CMS-2567 regarding Tag F 247, is written solely to maintain certification in the Medicare and Medical Assistance programs. We wish to preserve our right to dispute these findings in their entirely should any remedies be imposed. Chosen Valley Care Center ensures that each resident receives proper notice before the resident□s room or roommate in the facility is changed. Chosen Valley Care Center is sensitive to the trauma a move or change of roommate causes some residents, and attempts to be as accommodating as possible. Chosen Valley Care Center will give a resident as much notice as possible that they are getting a new roommate. The policy and procedure for notification of room transfer were reviewed and found appropriate. R94 has not recently changed rooms or has not gotten a new roommate. All residents have the potential to be affected by this deficient practice. All licensed and unlicensed staff will be re-educated on the room change policy at our mandatory in-services on July 17, 18, and 21st, 2014. The Licensed Social Worker will monitor compliance by completing the Room Change Monitor form. The monitor results will be discussed at the monthly QAPI Steering Committee for three months and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING _____ B. WING _____	06/26/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 247	Continued From page 4 being made and any information that will assist the roommate in accepting his or her new roommate.	F 247	will be reviewed at quarterly QI meetings for one year.	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to secure medically necessary equipment related to the use of a continuous positive airway pressure (CPAP) for 1 of 1 resident (R2) reviewed for service coordination. Findings include: R2 was admitted on 5/3/14 and diagnoses per physician visit dated 5/6/14 included dementia, vascular with a functional decline, hypothyroidism, chronic kidney disease stage 4, functional decline and debility and degenerative joint disease. The admission Minimum Data Set (MDS) dated 5/09/14 indicated that R2's brief interview for mental status (BIMS) was 3, indicating severe cognitive impairment and needed extensive assist with all activities of daily living (ADL's) except eating. R2's care plan dated 6/12/14 included a problem indicating that R2 experienced shortness of breath at night because of obstructive sleep	F 250	This plan and response to CMS-2567 regarding Tag F250, is written solely to maintain certification in the Medicare and Medical Assistance programs. We wish to preserve our right to dispute these findings in their entirely should any remedies be imposed. Chosen Valley Care Center ensures that each resident receives the medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Resident R2 CPAP machine was inspected by Northwest Respiratory and was fitted for a new filter and new tubing on 7/14/14. The policies and procedures for CPAP/BiPAP has been reviewed and found appropriate.	8/1/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING _____ B. WING _____	06/26/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 5 apnea. Interventions included using continuous positive airway pressure (CPAP) for R2 at night and removing in the morning. Staff was to observe breathing pattern and report changes to physician. A signed physician order dated 6/11/14 included an order for R2 to have CPAP at night on current home settings. Record review of the electronic medication administration record (e-MAR) indicated that the CPAP had not been used since it had been ordered on June 11, 2014. Nurse's notes dated 6/11/14 at 6:05 p.m. indicated that the CPAP was not usable at this time. Response: will continue to monitor. During an interview on 6/23/14 at 2:42 p.m., R2 ' s family (F)-A stated that R2 should be wearing his CPAP at night but hadn't been wearing it since R2 had been in the facility. F-A felt the lack of CPAP use was why R2 was up at night and not sleeping well. Medical Records (MR)-B indicated during an interview on 6/24/14 at 8:22 a.m. that R2 had a CPAP machine that f-A had brought in a couple of weeks ago, but it was old and not in working condition. MR-B stated that Northwest (NW) Respiratory was called regarding ordering parts for it. F-A was told that R2 may need to go back to Mayo Clinic for another sleep study. MR-B stated that she had been on vacation last week and did not know what was done regarding the CPAP. On 6/24/14 at 12:10 p.m. MR-B indicated a technician from NW Respiratory looked at R2 ' s CPAP last week and he was unable to fix the machine. MR-B indicated NW Respiratory was	F 250	All residents who residents who reside at Chosen Valley Care Center have the potential to be affected by this deficient practice. All licensed and unlicensed staff will be re-educated on inspecting medical equipment upon arrival at CVCC and to notify physician immediately if medical equipment is inoperable on July 17th, 18th and 21ST 2014. The Director of Nursing/designee will complete a Medical Equipment from Home Monitor that was developed to ensure that residents who bring medical equipment from home is in working order and if not that the physician is notified immediately. The monitor will be monthly for three months and then quarterly after that. If noncompliance is noted, additional auditing and staff training will be done. Results from monitors will be reviewed at QAPI Steering Committee meeting for 3 months and at Quarterly Quality Improvement meeting for one full year.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING _____ B. WING _____	06/26/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 6 called and stated that someone would come out this week to look at it. They would not be able to replace the filter, but MR-B stated that the facility could rent one. MR-B stated that R2 had not used the CPAP since it had been ordered. During an interview with the registered nurse (RN)-A on 6/25/14 at 11:08 a.m., when asked who would be responsible for following up with making sure R2 had a functioning CPAP weather it was his personal one from home or securing a different one timely. RN-A stated it would be either herself or the medical records person MR-B. RN-A stated that MR-B sent a picture of what the machine looked like the following day after it was not working to NW Respiratory to try to find replacement parts for it. The technician came out last week but was unable to work with it because he was not qualified. RN indicated that the resident would probably need a sleep study but RN-A needed to run it past F-A. When asked if R2 ' s physician was notified about not using the machine since the order of 6/11/14, RN-A stated she would look into that. Review of medical record showed no documentation of the physician being notified. A policy titled CPAP/BiPAP Support dated 11/10 indicated that the CPAP may be appropriate for improving arterial oxygenation in residents with respiratory insufficiency, obstructive sleep apnea, or restrictive/obstructive lung disease.	F 250		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of	F 312		8/1/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING _____ B. WING _____	06/26/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 7 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 grooming which included clean nails was offered for 2 of 3 residents (R20 and R100) reviewed for activities of daily living. Findings include: R20 was observation on 6/23/14 at 6:36 p.m. to have visible debris under nail bed of fingers. Again during another observation of R20 on 6/25/14 at 9:08 a.m. R20's fingernails continued to have debris under nail bed which had not been cleaned. R20 was re-admitted to this facility on 5/16/14, with the following diagnoses (not all-inclusive): dyspnea and respiratory abnormalities; diastolic heart failure; chronic systolic heart failure, and congestive heart failure. During an interview on 6/25/14 at 10:25 a.m., R20 stated that she had not noticed that her nails were dirty (soiled with debris.) She further added that she had received a bath yesterday and nails were not cleaned at that time. Review of the care plan noted the following: Problem: I need help with dressing and keeping myself clean related to my recent left total shoulder arthroplasty and general debility with	F 312	This plan and response to CMS-2567 regarding Tag 312, is written solely to maintain certification in the Medicare and Medical Assistance programs. We wish to preserve our right to dispute these findings in their entirely should any remedies be imposed. Nail Care Policies and Procedures have been reviewed and found appropriate. When resident (R20) and resident (R100) were discovered to have unclean finger nails, nail care was provided by nursing staff. All residents who residents who reside at Chosen Valley Care Center have the potential to be affected by this deficient practice. All licensed and unlicensed staff were re-educated on nail care policies and procedures on July 17th, 18th and 21ST 2014. The Director of Nursing/designee will complete a Nail Care Monitor that was developed to ensure residents nails are clean and trimmed. The monitor will be completed 5 times a week for 4 weeks	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING _____ B. WING _____	06/26/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 8 vision impairments. Goal: I will be clean, appropriately dressed and well groomed daily. Interventions: .....trim my nails on bath day (Responsible for this task are the nursing assistants). Interview with trained medication aid (TMA)-A on 6/25/14 at 10:30 a.m. stated that the nursing assistants who are giving residents a bath are responsible for nail care except if the resident is diabetic. At the same date and time TMA-A observed R20 ' s finger nails and verified the nails were soiled. Interview with registered nurse (RN)-A at 10:45 a.m., stated that nursing assistants (NA) are to clean nails on bath day. She then looked at R20's nails and verified that R20's nails were in need of cleaning as they were soiled with debris. R100 had been admitted on 1/16/14. R100's quarterly Minimum Data Set (MDS) dated 4/13/14, identified diagnoses of but not limited to heart failure, diabetes mellitus and required assist of one for personal hygiene. During observation on 6/24/14, at 10:39 a.m., R100 had debris under fingernails on right hand. This was also noted during observation on 6/25/14; at 8:52 a.m. R100's fingernails on right hand remained soiled with debris underneath nail beds. On 6/25/14, at 12:08 p.m., R100's fingernails on right hand remained soiled with debris underneath nail beds. R100 had stated at the time, when asked if nails were cleaned during her bath R100 said that they never do clean nails with bath and when asked if nails were ever cleaned at any time R100 said they should I suppose.	F 312	and randomly thereafter. If noncompliance is noted, additional auditing and staff training will be done. Results from monitors will be reviewed at QAPI Steering Committee meeting for 3 months and at Quarterly Quality Improvement meeting for one full year.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING _____ B. WING _____	06/26/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 9 During observation on 6/25/14, at 12:14 p.m., registered nurse (RN)-A verified R100's fingernails on right hand were soiled with debris underneath the nail beds. RN-A had stated at the time nursing assistants are responsible to clean underneath fingernails on resident bath days, cleaning of fingernails not documented, nursing assistants are expected to do as part of bath routine. R100's current care plan dated 6/16/14, identified focus of need help with dressing and keeping myself clean with interventions of but not limited to give tub bath or shower, help bathe parts unable to do, shampoo hair and trim nails on bath day. Document review of facility bath schedule dated 5/27/14, identified R100's bath day was every Tuesday. R2 had her bath on Tuesday June 24, 2014. During interview on 6/25/14, at 2:07 p.m., director of nursing had stated she would expect fingernails to be cleaned anytime fingernails are dirty/soiled. Document review facility policy Care of Fingernails/Toenails dated revised 10/10, read, " The purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. General Guidelines 1. Nail care includes daily cleaning and regular trimming. 2. Proper nail care can aid in the prevention of skin problems around the nail bed. Documentation The following information should be recorded in the resident's medical record: 1. The date and time that nail care was given."	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING _____ B. WING _____	06/26/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 10	F 323		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to conduct a comprehensive fall assessment following falls for 1 of 3 residents (R20) reviewed for accidents. In addition, the facility failed to assess and develop interventions for 1 of 1 resident (R20) reviewed who had experienced a choking episode. Findings include: Lack of falls assessment and interventions to prevent further falls from occurring: R20 had been re-admitted to the facility on 5/16/14 from her home, with diagnoses including (not all inclusive): acute kidney failure; dyspnea and respiratory abnormalities; diastolic heart failure; chronic systolic heart failure; and congestive heart failure. During an observation on 6/23/14 at 6:36 p.m., R20 was seated in a wheelchair in her room, slumped towards the front of her wheelchair, and was making snoring sounds. On 6/24/14 at 8:54 a.m., R20 was observed to be seated in a wheelchair in front of a tray table. She was	F 323	This plan and response to CMS-2567 regarding Tag F323, is written solely to maintain certification in the Medicare and Medical Assistance programs. We wish to preserve our right to dispute these findings in their entirely should any remedies be imposed. Choking and Fall Policies and Procedures have been reviewed and found appropriate. Resident (R20) falls on 6/10/14 and 6/15/14 have been reviewed and comprehensive fall assessment was completed and possible root causes identified. Resident interventions were reviewed and care plan was updated. On 6/16/14 the LPN noted in progress notes that Resident (R20) had a choking spell in the dining room this am during brunch. Upon review the LPN noted that she had been coughing and coughing but she was able to cough it out herself. The	8/1/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING _____ B. WING _____	06/26/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 11 slumped forward with her head on a piece of toast, sleeping. Incident/Accident reports were requested from the director of nursing (DON) for R20. The DON stated R20 had experienced only one fall, 6/10/14, since her re-admission. A form identified as #2289 Fall, dated 6/10/14, was provided as the fall documentation. The documentation included: "Rsdt [resident] was observed sitting on floor in front of bed. Rsdt was assisted by PT [patient] and writer. Rsdt reported that she was sitting on her bed when she started slipping to the floor." The documentation also indicated the resident had been wearing gripper socks on both feet, her call light within reach, and her bed was in the lowest position. The form included a section to identify "Predisposing Environmental Factors" and "other" was checked, with no defining details. In addition, in the sections identified as "Predisposing Physiological Factors" and Predisposing Situation Factors" again "other" was checked with no defining details. No immediate interventions were identified and no fall investigation was conducted. Although the DON had provided only one fall report, review of the interdisciplinary progress notes (IDT) from 6/2/14 to present (6/26/14), the fall from 6/10/14 was noted, as was another fall having occurred on 6/15/14. Staff entered room and noted R20 as being seated on the foot rest of her recliner. R20 told staff that she was trying to move forward which caused the recliner to tip and she slid forward onto the footrest of the recliner. Review of the IDT notes did not identify this as a fall and no assessment or interventions were developed to prevent this from occurring again.	F 323	Heimlich maneuver was not done. On 6/16/14 RN Case Manager was aware of incident and reviewed diet and diagnosis. Resident was determined to be safe to eat unattended in room. As an intervention resident eats her meals in large dining room where licensed staff, nursing assistants and dietary assistants are present and resident is able to be observed. All residents who residents who reside at Chosen Valley Care Center have the potential to be affected by these deficient practices. All licensed and unlicensed staff were re-educated on choking and Fall Policies and Procedures on July 17th, 18th and 21ST 2014. The Director of Nursing/designee will complete a Falls - Root Cause Determination & Intervention Monitor that was developed to ensure that root causes are determined to initiate appropriate interventions. The monitor will be completed for 20 consecutive falls and randomly thereafter. A second Monitor, Choking Incident & Comprehensive Assessment Monitor will be completed monthly for one year. If noncompliance is noted, additional auditing and staff training will be done. Compliance monitors will be reviewed at QAPI Steering Committee meeting for 3 months and at Quarterly Quality Improvement meeting for one full year.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING _____ B. WING _____	06/26/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 12	F 323		

Review of a Fall Risk Evaluation conducted 6/2/14, indicated the resident had not experienced falls in the past 3 months, did not walk, required the use of assistive devices for mobility, and had poor vision. There was no further assessment of the resident's issues with fatigue, feeling down, or posture identified on the Fall Risk Evaluation. There was also no more comprehensive assessment conducted following the falls on 6/10 and 6/15/14.

During interview with the registered nurse/case manager and the director of nursing (DON), on 6/25/14 at 1:02 p.m., the DON stated she had been unaware of the 6/15/14 fall. They both verified there had been no further assessments conducted to determine causal factor for R20's falls which occurred on 6/10 and on 6/15/14, and no new interventions developed.

Lack of assessment for chocking incident:
During review of R20's progress notes; it was revealed a choking episode had occurred on 6/16/14. The progress note on 6/16/14 identified: Action: monitor for choking and Response: staff will monitor. The DON had not provided any incident report information related to a choking episode for R20.

R20 was approached on 6/24/14 at 10:17 a.m., to be interviewed, however she stated she did not feel well and refused. On 6/25/14 at 9:37 a.m., an interview was conducted with R20. R20 stated that she has days where she is feeling up, and days where she is feeling down. She said this was one of those down days, and that she was not feeling well. R20 stated that she was sore (pointing to the chest and back area) and stated that she had experienced a choking episode the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING _____ B. WING _____	06/26/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 13 other night. R20 had eaten a soggy French fry mixed with some meat and when she tried to swallow this combination, she began to choke, and staff had to do the Heimlich maneuver on her. She added that finally she was able to stand up and the food passed down. R20 stated that she didn't realize how much force they exerted on her and how sore she was as a result of this episode. A post survey phone interview with the DON on 6/27/14 at 1:03 p.m., confirmed the DON had not been unaware of the resident's 6/16/14 choking incident and no chocking risk assessment nor interventions were developed to decrease the reoccurrence of choking again.	F 323		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the use of clean string call light cords in bathrooms for 19 of 19 residents (R100, R57, R65, R53, R43, R18, R26, R73, R40, R63, R98, R20, R62, R83, R21, R94, R23, R115 and R56) reviewed for environment. Findings include: On 6/23/14, at 2:38 p.m., R43, R18, R26 and R73's bathroom string call light cord had been	F 465	This plan and response to CMS-2567 regarding Tag F 465, is written solely to maintain certification in the Medicare and Medical Assistance programs. We wish to preserve our right to dispute these findings in their entirely should any remedies be imposed. Chosen Valley Care Center ensures that the necessary housekeeping and maintenance services are provided to	8/1/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING _____ B. WING _____	06/26/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 14 observed to be discolored (dark brown). On 6/25/14, at 9:30 a.m., bathroom string call light cord had been observed to be soiled with debris and discolored. On 6/23/14, at 2:42 p.m., R40, R63 and R98's bathroom string call light cord had been observed to be discolored (dark brown). On 6/25/14, at 9:31 a.m., bathroom string call light cord had been observed to be soiled with debris and discolored. On 6/23/14, at 2:51 p.m., R94, R23, R115 and R56's bathroom string call light cord had been observed to be dirty. On 6/25/14, at 9:35 a.m., bathroom string call light cord had been observed to be soiled with debris and discolored. On 6/24/14, at 10:16 a.m., R20, R62, R83 and R21's bathroom string call light cord had been observed to be dirty. On 6/25/14, at 9:33 a.m., bathroom string call light cord had been observed to be soiled with debris and discolored with particles of brown colored substance on and by knot tied in sting call light cord. On 6/24/14, at 10:22 a.m., R100, R57, R65 and R53's bathroom string call light cord had been observed to be dirty and discolored (dark brown). On 6/25/14, at 9:39 a.m., bathroom string call light cord had been observed to be soiled with debris and discolored. During interview on 6/25/14, at 9:34 a.m., housekeeper-A had stated string call light cords in bathrooms are cleaned by wiping down with a rag sprayed with cleaning solution. Housekeeper-A when asked how often string call light cords are cleaned, had stated cannot say do every single time, but try to clean everything hands touch.	F 465	maintain a sanitary, orderly, and comfortable environment for our residents. On July 10, 2014 we replaced all current call station cords in the building with a new plastic call station cord. The Environmental Services assignment sheets have been updated and the task has been added to clean all call station cords daily and change as needed. All residents who reside at Chosen Valley Care Center have the potential to be affected by this deficient practice. All licensed and unlicensed staff will be educated on the new plastic call station cords and the new daily cleaning schedule of the call station cords on July 17, 18, and 21st, 2014. The Environmental Services Supervisor will complete a Call Station Cord Monitor. The monitor will be completed monthly for three months and the results will be reviewed at the QAPI Steering Committee meeting for three months. The monitor will also be presented at the quarterly Quality Improvement Meeting for one year. If noncompliance is noted, additional monitoring and staff training will be done.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING _____ B. WING _____	06/26/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 15 During tour of environment on 6/25/14, at 12:24 p.m., director of environmental services (DES)-C had verified the above. DES-C had stated did not know what policy was for cleaning string pull light cords in bathrooms. During interview on 6/25/14, at 12:31 p.m., environmental services supervisor (ESS)-D had stated string call light cords in bathrooms have been replaced when. ESS-D had stated string call light cords are cleaned during general cleaning. ESS-D handed surveyor policies at the time and stated cleaning of the string call light cords in bathrooms is done in general cleaning or resident's rooms. ESS-D had stated in the job description where it reads " call light " this also includes the bathroom string call light cord. Document review of the facility CHOSEN VALLEY CARE CENTER, INC. JOB DESCRIPTION ENVIRONMENTAL SERVICES dated revised 10/1/09, read, "WORK PERFORMED WHEN SCHEDULED TO CLEAN ROOMS 1. Wiping above light, call light..." Document review of the facility General Job Duties for Environmental services/ House Keeping for each wing undated, read, "Environmental services staff maintain and clean all areas for a healthy living environment that enhances the lives of our residents and staff. When cleaning an area it is your responsibility to notice all surfaces including walls, ceilings, and floors."	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/23/2014**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Chosen Valley Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Please return the plan of correction for the Fire Safety Deficiencies (K-tags) to: Health Care Fire Inspections State Fire Marshal Division 444 Cedar St., Suite 145 St Paul, MN 55101-5145, or By e-mail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH	K 000	EPOC	

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

Electronically Signed | 07/15/2014

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
	245423	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/23/2014**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Chosen Valley Care Center is a 1-story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1975 and was determined to be of Type V(111) construction. In 1998, an addition was constructed and was determined to be of Type V(111) construction. In 2001, an addition was constructed and was determined to be of Type II(000) construction. In 2002, a canopy was constructed and was determined to be of Type V(111) construction. The construction type was changed after review of the architectural drawings that are on hand for the facility. Because the original building and the 3 addition are of the same type of construction and meet the construction type allowed for existing buildings, The facility will be surveyed as a Type V(111) building. The building is fully sprinkled. The facility has a fire alarm system with full corridor smoke detection and that is monitored for automatic fire department notification. The facility has a capacity of 78 beds and had a census of 76 at the time of the survey.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/23/2014**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2	K 000		
K 144 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the emergency generator in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 Chapter 6-4.1. The deficient practice could affect all 76 residents. Findings include: On facility tour between 1:30 PM and 3:30 PM on 06/23/2014, documentation review of the weekly inspection logs (06/23/2013 to 06/23/2014) for the diesel emergency generator revealed that the weekly operational inspection was missed for the week of 09/16/2013. This deficient practice was confirmed by the Director of Maintenance (GG) at the time of discovery.	K 144	The Director of Environmental Services will monitor compliance by completing the Emergency Generator Audit. The audit will be completed weekly for one month and then it will be completed quarterly. The monitor results will be discussed at the monthly QAPI Steering Committee for three months and will be reviewed at the quarterly QI meetings for one year.	8/11/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/23/2014**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	Continued From page 3 *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 144		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
July 9, 2014

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5423024

Dear Mr. Backen:

The above facility was surveyed on June 23, 2014 through June 26, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted 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 after the statement, "This Rule 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 me.

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00750	A. BUILDING: _____ B. WING _____	06/26/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00750	A. BUILDING: _____ B. WING _____	06/26/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Department of Health orders being submitted to you electronically. 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. On June 23, 24, 25 and 26, 2014, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00750	A. BUILDING: _____ B. WING _____	06/26/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 435	MN Rule 4658.0210 Subp. 2 A.B. Room Assignments Room assignment complaints. A nursing home must develop and implement written policies and procedures for addressing resident complaints, including complaints regarding room assignments and roommates. At a minimum, the policies and procedures must include the following: A. a mechanism for informal dispute resolution of room assignment and roommate complaints; and B. a procedure for documenting the complaint and its resolution. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide notice for change of roommate assignments, prior to the change occurring for 1 of 2 residents (R94) who had a recent room change. Findings include: R94 reported a new roommate had moved in within the last couple of weeks without prior notification from the facility during interview on 6/24/14 at 11:24 a.m. R94 indicated that roommates come and go and he knows when they're coming in when they start bringing in things for the resident. However, the staff doesn't	2 435		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00750	A. BUILDING: _____ B. WING _____	06/26/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 435	Continued From page 3 inform R94 before the roommate moves into the room. Review of R94 ' s record lacked documentation that notification for the roommate change had been provided for the most recent roommate. R94's quarterly Minimum Data Set (MDS) dated 4/20/14 indicated that the resident had intact cognition with a Brief Interview for Mental Status (BIMS) score of 15. During an interview on 6/25/14 at 7:25 a.m., registered nurse, (RN)-B, indicated that she was unable to find any documentation that R94 was notified of his new roommate. RN-B verified that R94 did receive a new roommate recently during the past month. A policy titled Transfer, Room to Room, dated 12/2012, indicated that a roommate will be informed of any new transfer into his/her room. Such information will include why the transfer is being made and any information that will assist the roommate in accepting his or her new roommate. Suggested Method of Correction: The director of nursing (DON) or designee could educate the social worker/designee on policies and procedures for when to notify the resident(s) of room/roommate changes, and then could educate staff. The DON or designee could also perform audits of resident records to determine if the resident(s) had been notified as appropriate. Time Period for Correction: Twenty one (21) days.	2 435		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00750	A. BUILDING: _____ B. WING _____	06/26/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 860	Continued From page 4	2 860		
2 860	MN Rule 4658.0520 Subp. 2 F. Adequate and Proper Nursing Care; Hands-Feet Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. per care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure grooming which included clean nails was offered for 2 of 3 residents (R20 and R100) reviewed for activities of daily living. Findings include: R20 was observation on 6/23/14 at 6:36 p.m. to have visible debris under nail bed of fingers. Again during another observation of R20 on 6/25/14 at 9:08 a.m. R20's fingernails continued to have debris under nail bed which had not been cleaned. R20 was re-admitted to this facility on 5/16/14, with the following diagnoses (not all-inclusive): dyspnea and respiratory abnormalities; diastolic heart failure; chronic systolic heart failure, and congestive heart failure. During an interview on 6/25/14 at 10:25 a.m., R20 stated that she had not noticed that her nails were dirty (soiled with debris.) She further added that she had received a bath yesterday and nails were not cleaned at that time.	2 860		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00750	A. BUILDING: _____ B. WING _____	06/26/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 860	Continued From page 5 Review of the care plan noted the following: Problem: I need help with dressing and keeping myself clean related to my recent left total shoulder arthroplasty and general debility with vision impairments. Goal: I will be clean, appropriately dressed and well groomed daily. Interventions: .....trim my nails on bath day (Responsible for this task are the nursing assistants). Interview with trained medication aid (TMA)-A on 6/25/14 at 10:30 a.m. stated that the nursing assistants who are giving residents a bath are responsible for nail care except if the resident is diabetic. At the same date and time TMA-A observed R20 ' s finger nails and verified the nails were soiled. Interview with registered nurse (RN)-A at 10:45 a.m., stated that nursing assistants (NA) are to clean nails on bath day. She then looked at R20's nails and verified that R20's nails were in need of cleaning as they were soiled with debris. R100 had been admitted on 1/16/14. R100's quarterly Minimum Data Set (MDS) dated 4/13/14, identified diagnoses of but not limited to heart failure, diabetes mellitus and required assist of one for personal hygiene. During observation on 6/24/14, at 10:39 a.m., R100 had debris under fingernails on right hand. This was also noted during observation on 6/25/14; at 8:52 a.m. R100's fingernails on right hand remained soiled with debris underneath nail beds. On 6/25/14, at 12:08 p.m., R100's fingernails on right hand remained soiled with debris underneath nail beds. R100 had stated at the time, when asked if nails were cleaned during her bath R100 said that they never do clean nails	2 860		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00750	A. BUILDING: _____ B. WING _____	06/26/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 860	Continued From page 6 with bath and when asked if nails were ever cleaned at any time R100 said they should I suppose. During observation on 6/25/14, at 12:14 p.m., registered nurse (RN)-A verified R100's fingernails on right hand were soiled with debris underneath the nail beds. RN-A had stated at the time nursing assistants are responsible to clean underneath fingernails on resident bath days, cleaning of fingernails not documented, nursing assistants are expected to do as part of bath routine. R100's current care plan dated 6/16/14, identified focus of need help with dressing and keeping myself clean with interventions of but not limited to give tub bath or shower, help bathe parts unable to do, shampoo hair and trim nails on bath day. Document review of facility bath schedule dated 5/27/14, identified R100's bath day was every Tuesday. R2 had her bath on Tuesday June 24, 2014. During interview on 6/25/14, at 2:07 p.m., director of nursing had stated she would expect fingernails to be cleaned anytime fingernails are dirty/soiled. Document review facility policy Care of Fingernails/Toenails dated revised 10/10, read, " The purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. General Guidelines 1. Nail care includes daily cleaning and regular trimming. 2. Proper nail care can aid in the prevention of skin problems around the nail bed. Documentation The following information should be recorded in	2 860		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00750	A. BUILDING: _____ B. WING _____	06/26/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 860	Continued From page 7 the resident's medical record: 1. The date and time that nail care was given." SUGGESTED METHOD OF CORRECTION: The director of nursing could review and revise policies and procedures for performing activities of daily living, such as nail care. The director of nursing could educate all staff to provide nail care. The director of nursing could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 860		
21426	MN St. Statute 144A.04 Subd. 4 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00750	A. BUILDING: _____ B. WING _____	06/26/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 8 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 employees (EE-A) received a baseline tuberculosis screening. Findings include: Minnesota Department of Health guide for Regulations for Tuberculosis Control in Minnesota Health Care Settings July 2013 reads, "An employee may begin working with patients after a negative TB [tuberculosis] symptom screen (i.e., first step) dates within 90 days before hire. the second TST [tuberculin skin test] may be performed after HCW starts working with patients." EE-A had a hire date of 4/24/14. Document review of facility employee tuberculin skin test records revealed lack of evidence of tuberculin skin test administered for EE-A or previously received before hire date. During interview on 6/24/14 at 0700 the infection control nurse RN-(B) stated that they had tubersol available during the time of this employee's hired date to administer tuberculin skin tests. RN-B verified that EE-A had worked since hire date of 4/24/14 and that EE-A had not received the tuberculin skin test upon hire. The policy titled Tuberculosis, Employee Screening dated/revised 5/3/13 indicated that all employees shall be screened for signs and symptoms of tuberculosis (TB) infection and disease, using a designated screening tool and if available be tested for the presence of infection by administering either a single TB blood test of a two-step tuberculin skin test (TST). SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service employees responsible for giving and monitoring TB status of new employees the current standard for giving TB.	21426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00750	A. BUILDING: _____ B. WING _____	06/26/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 9 TIME PERIOD FOR CORRECTION: Seven (7) days.	21426		
21495	MN Rule 4658.1005 Subp. 5 Social Services; Providing Social Services Subp. 5. Providing social services. Social services must be provided on the basis of identified social service needs of each resident, according to the comprehensive resident assessment and comprehensive plan of care described in parts 4658.0400 and 4658.0405. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to secure medically necessary equipment related to the use of a continuous positive airway pressure (CPAP) for 1 of 1 resident (R2) reviewed for service coordination. Findings include: R2 was admitted on 5/3/14 and diagnoses per physician visit dated 5/6/14 included dementia, vascular with a functional decline, hypothyroidism, chronic kidney disease stage 4, functional decline and debility and degenerative joint disease. The admission Minimum Data Set (MDS) dated 5/09/14 indicated that R2's brief interview for mental status (BIMS) was 3, indicating severe cognitive impairment and needed extensive assist with all activities of daily living (ADL's) except eating. R2's care plan dated 6/12/14 included a problem indicating that R2 experienced shortness of	21495		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00750	A. BUILDING: _____ B. WING _____	06/26/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21495	Continued From page 10	21495		

breath at night because of obstructive sleep apnea. Interventions included using continuous positive airway pressure (CPAP) for R2 at night and removing in the morning. Staff was to observe breathing pattern and report changes to physician.

A signed physician order dated 6/11/14 included an order for R2 to have CPAP at night on current home settings.

Record review of the electronic medication administration record (e-MAR) indicated that the CPAP had not been used since it had been ordered on June 11, 2014.

Nurse's notes dated 6/11/14 at 6:05 p.m. indicated that the CPAP was not usable at this time. Response: will continue to monitor. During an interview on 6/23/14 at 2:42 p.m., R2 ' s family (F)-A stated that R2 should be wearing his CPAP at night but hadn't been wearing it since R2 had been in the facility. F-A felt the lack of CPAP use was why R2 was up at night and not sleeping well.

Medical Records (MR)-B indicated during an interview on 6/24/14 at 8:22 a.m. that R2 had a CPAP machine that f-A had brought in a couple of weeks ago, but it was old and not in working condition. MR-B stated that Northwest (NW) Respiratory was called regarding ordering parts for it. F-A was told that R2 may need to go back to Mayo Clinic for another sleep study. MR-B stated that she had been on vacation last week and did not know what was done regarding the CPAP. On 6/24/14 at 12:10 p.m. MR-B indicated a technician from NW Respiratory looked at R2 ' s CPAP last week and he was unable to fix the machine. MR-B indicated NW Respiratory was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00750	A. BUILDING: _____ B. WING _____	06/26/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21495	Continued From page 11 called and stated that someone would come out this week to look at it. They would not be able to replace the filter, but MR-B stated that the facility could rent one. MR-B stated that R2 had not used the CPAP since it had been ordered. During an interview with the registered nurse (RN)-A on 6/25/14 at 11:08 a.m., when asked who would be responsible for following up with making sure R2 had a functioning CPAP weather it was his personal one from home or securing a different one timely. RN-A stated it would be either herself or the medical records person MR-B. RN-A stated that MR-B sent a picture of what the machine looked like the following day after it was not working to NW Respiratory to try to find replacement parts for it. The technician came out last week but was unable to work with it because he was not qualified. RN indicated that the resident would probably need a sleep study but RN-A needed to run it past F-A. When asked if R2's physician was notified about not using the machine since the order of 6/11/14, RN-A stated she would look into that. Review of medical record showed no documentation of the physician being notified. A policy titled CPAP/BiPAP Support dated 11/10 indicated that the CPAP may be appropriate for improving arterial oxygenation in residents with respiratory insufficiency, obstructive sleep apnea, or restrictive/obstructive lung disease. SUGGESTED METHOD OF CORRECTION: The director of nursing could ensure arrangements were made to provide residents with medically necessary equipment needs for the use of a CPAP while in the facility.	21495		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00750	A. BUILDING: _____ B. WING _____	06/26/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21495	Continued From page 12 TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21495		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the use of clean string call light cords in bathrooms for 19 of 19 residents (R100, R57, R65, R53, R43, R18, R26, R73, R40, R63, R98, R20, R62, R83, R21, R94, R23, R115 and R56) reviewed for environment. Findings include: On 6/23/14, at 2:38 p.m., R43, R18, R26 and R73's bathroom string call light cord had been observed to be discolored (dark brown). On 6/25/14, at 9:30 a.m., bathroom string call light cord had been observed to be soiled with debris and discolored. On 6/23/14, at 2:42 p.m., R40, R63 and R98's bathroom string call light cord had been observed to be discolored (dark brown). On 6/25/14, at 9:31 a.m., bathroom string call light cord had been observed to be soiled with debris and discolored. On 6/23/14, at 2:51 p.m., R94, R23, R115 and R56's bathroom string call light cord had been observed to be dirty. On 6/25/14, at 9:35 a.m.,	21665		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00750	A. BUILDING: _____ B. WING _____	06/26/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21665	Continued From page 13 bathroom string call light cord had been observed to be soiled with debris and discolored. On 6/24/14, at 10:16 a.m., R20, R62, R83 and R21's bathroom string call light cord had been observed to be dirty. On 6/25/14, at 9:33 a.m., bathroom string call light cord had been observed to be soiled with debris and discolored with particles of brown colored substance on and by knot tied in sting call light cord. On 6/24/14, at 10:22 a.m., R100, R57, R65 and R53's bathroom string call light cord had been observed to be dirty and discolored (dark brown). On 6/25/14, at 9:39 a.m., bathroom string call light cord had been observed to be soiled with debris and discolored. During interview on 6/25/14, at 9:34 a.m., housekeeper-A had stated string call light cords in bathrooms are cleaned by wiping down with a rag sprayed with cleaning solution. Housekeeper-A when asked how often string call light cords are cleaned, had stated cannot say do every single time, but try to clean everything hands touch. During tour of environment on 6/25/14, at 12:24 p.m., director of environmental services (DES)-C had verified the above. DES-C had stated did not know what policy was for cleaning string pull light cords in bathrooms. During interview on 6/25/14, at 12:31 p.m., environmental services supervisor (ESS)-D had stated string call light cords in bathrooms have been replaced when. ESS-D had stated string call light cords are cleaned during general cleaning. ESS-D handed surveyor policies at the time and stated cleaning of the string call light cords in bathrooms is done in general cleaning or	21665		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00750	A. BUILDING: _____ B. WING _____	06/26/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21665	Continued From page 14 resident's rooms. ESS-D had stated in the job description where it reads " call light " this also includes the bathroom string call light cord. Document review of the facility CHOSEN VALLEY CARE CENTER, INC. JOB DESCRIPTION ENVIRONMENTAL SERVICES dated revised 10/1/09, read, "WORK PERFORMED WHEN SCHEDULED TO CLEAN ROOMS 1. Wiping above light, call light..." Document review of the facility General Job Duties for Environmental services/ House Keeping for each wing undated, read, "Environmental services staff maintain and clean all areas for a healthy living environment that enhances the lives of our residents and staff. When cleaning an area it is your responsibility to notice all surfaces including walls, ceilings, and floors." SUGGESTED METHOD OF CORRECTION: Administrator to monitor and educate staff for need to maintain environment in a clean and sanitary manner. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings.	21695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00750	A. BUILDING: _____ B. WING _____	06/26/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21695	Continued From page 15 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the use of clean string call light cords in bathrooms for 19 of 19 residents (R100, R57, R65, R53, R43, R18, R26, R73, R40, R63, R98, R20, R62, R83, R21, R94, R23, R115 and R56) reviewed for environment. Findings include: On 6/23/14, at 2:38 p.m., R43, R18, R26 and R73's bathroom string call light cord had been observed to be discolored (dark brown). On 6/25/14, at 9:30 a.m., bathroom string call light cord had been observed to be soiled with debris and discolored. On 6/23/14, at 2:42 p.m., R40, R63 and R98's bathroom string call light cord had been observed to be discolored (dark brown). On 6/25/14, at 9:31 a.m., bathroom string call light cord had been observed to be soiled with debris and discolored. On 6/23/14, at 2:51 p.m., R94, R23, R115 and R56's bathroom string call light cord had been observed to be dirty. On 6/25/14, at 9:35 a.m., bathroom string call light cord had been observed to be soiled with debris and discolored. On 6/24/14, at 10:16 a.m., R20, R62, R83 and R21's bathroom string call light cord had been observed to be dirty. On 6/25/14, at 9:33 a.m., bathroom string call light cord had been observed to be soiled with debris and discolored with particles of brown colored substance on and by knot tied in sting call light cord.	21695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00750	A. BUILDING: _____ B. WING _____	06/26/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21695	Continued From page 16 On 6/24/14, at 10:22 a.m., R100, R57, R65 and R53's bathroom string call light cord had been observed to be dirty and discolored (dark brown). On 6/25/14, at 9:39 a.m., bathroom string call light cord had been observed to be soiled with debris and discolored. During interview on 6/25/14, at 9:34 a.m., housekeeper-A had stated string call light cords in bathrooms are cleaned by wiping down with a rag sprayed with cleaning solution. Housekeeper-A when asked how often string call light cords are cleaned, had stated cannot say do every single time, but try to clean everything hands touch. During tour of environment on 6/25/14, at 12:24 p.m., director of environmental services (DES)-C had verified the above. DES-C had stated did not know what policy was for cleaning string pull light cords in bathrooms. During interview on 6/25/14, at 12:31 p.m., environmental services supervisor (ESS)-D had stated string call light cords in bathrooms have been replaced when. ESS-D had stated string call light cords are cleaned during general cleaning. ESS-D handed surveyor policies at the time and stated cleaning of the string call light cords in bathrooms is done in general cleaning or resident's rooms. ESS-D had stated in the job description where it reads " call light " this also includes the bathroom string call light cord. Document review of the facility CHOSEN VALLEY CARE CENTER, INC. JOB DESCRIPTION ENVIRONMENTAL SERVICES dated revised 10/1/09, read, "WORK PERFORMED WHEN SCHEDULED TO CLEAN ROOMS 1. Wiping above light, call light..."	21695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00750	A. BUILDING: _____ B. WING _____	06/26/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21695	Continued From page 17 Document review of the facility General Job Duties for Environmental services/ House Keeping for each wing undated, read, "Environmental services staff maintain and clean all areas for a healthy living environment that enhances the lives of our residents and staff. When cleaning an area it is your responsibility to notice all surfaces including walls, ceilings, and floors." SUGGESTED METHOD OF CORRECTION: The environmental director (ED) could provide a daily schedule for cleaning bathroom call light cords and perform weekly audits to ensure bathroom call light cords are clean. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	21695		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dignity was promoted for 1 of 1 resident (R7) who had to wait 21 minutes for help even though there was staff in the area who ignored his request for assistance. Findings include:	21805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00750	A. BUILDING: _____ B. WING _____	06/26/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 18 R7's computer generated care plan dated 1/27/14; identified R7 had been admitted on 1/13/14, with diagnosis that included impaired cognition and hemiplegia secondary to right cerebral vascular accident (CVA.) The care plan noted R7 had impaired mobility and required staff assist to dress, move in wheel chair and change position. The care plan also identified R7 had the potential to fall related to hemiplegia (paralysis of one side of the body), was incontinent of bowel and bladder and directed staff to remind R7 to call for assist before attempting to transfer self. The care plan further indicated R7 required assist to toilet and read, "I don't like to ask for help." R7's quarterly Minimum Data Set (MDS) dated 4/13/14 indicated R7 had impaired cognition, had difficulty hearing in some environments such as a noisy setting, did not use hearing aids, and had difficulty communicating to others. On 6/25/14, at 9:30 a.m. R7 had been observed sitting in a wheel chair in the east hall common area, in front of a television (TV) which displayed a sports program. R7 was wearing a long sleeve shirt, unbuttoned at the sleeves which caused the sleeves to hang off the arm from the elbow down. Four other residents were noted sitting in front of the TV. Licensed practical nurse (LPN)-A observed sitting at the nurse ' s desk typing on a computer, and housekeeping staff observed in the area with cleaning equipment, entering and exiting resident rooms. Between 10:09 a.m. and 10:30 a.m. a total of 21 minutes. R7 was observed to call out for assistance with no intervention from staff in the area. At 10:30 a.m. the nursing assistant (NA) supervisor approached R7 and asked what was needed. R7 stated that he wanted to get up. At 10:37 a.m. two NA's took	21805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00750	A. BUILDING: _____ B. WING _____	06/26/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 19 R7 to his room, at that time R7 requested staff to button the shirt sleeves and to be toileted. On 6/25/14, at 1:26 p.m. LPN-A verified she had heard R7 call for help and stated she had not assisted R7 because she was documenting a verbal telephone order and wanted to finish that before she forgot. The housekeeper who was in the area of R7 calling for help was unavailable for interview. On 6/25/14, at 1:50 p.m. the director of nursing verified staff had not addressed R7's call for help timely and stated staff should have went to him and asked him what he needed at the time he first called out for help. On 6/26/14, at 9:11 a.m. licensed social worker (LSW)-A verified R7 had not been treated in a dignified manner then LSW-A stated "That's not ok" in regards to not asking R7 what he needed when first called for help. Quality of Life-Dignity policy revised 10/09, was reviewed and noted each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Interpretation and implementation #11 included demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed by: a. Promptly responding to the residents' request for toileting assistance. SUGGESTED METHOD OF CORRECTION: The director of Nursing could in-service all employees on providing cares and services while providing dignity for each resident. TIME PERIOD FOR CORRECTION: Twenty-one	21805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00750	A. BUILDING: _____ B. WING _____	06/26/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 20 (21) days.	21805		