Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 17, 2023

Administrator
Cura Of Le Sueur
621 South 4th Street
Le Sueur, MN 56058

RE: CCN: 245416
Cycle Start Date: April 26, 2023

Dear Administrator:

On June 26, 2023, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 16, 2023

Administrator
Minnesota Valley Health Center Inc
621 South 4th Street
Le Sueur, MN 56058

RE: CCN: 245416
Cycle Start Date: April 26, 2023

Dear Administrator:

On April 26, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

DEPARTMENT CONTACT

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by July 26, 2023, (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 26, 2023, (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the

dates specified for compliance or the imposition of remedies.

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

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245416	A. BUILDING _____ B. WING _____	C 04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNESOTA VALLEY HEALTH CENTER INC	621 SOUTH 4TH STREET LE SUEUR, MN 56058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 4/24/23 - 4/26/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 4/24/23 - 4/26/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed: The following complaints were reviewed with no deficiency cited: H5416033C (MN76191), and H54161531C (MN86890). The following complaint was reviewed: H54161562C (MN92836) with a deficiency cited at (F689). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/23/2023

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

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F 000	Continued From page 1 be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced	F 561		6/1/23

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F 561	Continued From page 2 by: Based on interview and document review, the facility failed to honor a resident's preference for assistance with personal hygiene for 1 of 1 resident (R16) reviewed for choices Findings include: R16's admission Minimum Data Set (MDS) assessment dated 2/8/23, indicated R16 admitted to the facility on 2/2/23, had moderately impaired cognition, no rejection of care, required two person physical assist with bed mobility, transfer, toilet use, and personal hygiene; one person physical assist with dressing, eating, locomotion on and off unit, utilized a wheelchair, diagnoses included: hip fracture, malnutrition, , fracture of left femur, delirium, peripheral vascular disease (blood circulation disorder), and anemia (low number of red blood cells). R16's care plan revised 4/7/23, indicated alteration in self care r/t (related to) non displaced subtrochanteric l (left) femur fx (fracture) as e/b (evidenced by) her non wt (weight) bearing status and need for assistance with her ADL's (activities of daily living), also had delirium issues at the hospital that impacted on her ability to provide her own cares, delirium has improved, 3/7/23-wt bear as tolerated and approach included: a-1 (assist of one) to dress/undress upper/lower body, encourage to participate as able, staff pull up pants and put socks/shoes on/off., personal hygiene: able to wash/dry face/hands, comb hair, apply deodorant/lotion, may need more assistance when distracted and having difficulty following directions, bathing: a 2 (assist of two) with slide board with transfers in/out of shower; a-1 to wash/dry upper/lower body, encourage to	F 561	R16 has discharged from the facility. However prior to discharge, it was verified that R16's preference for no male caregivers for personal cares was indicated in R16's careplan. A review of careplans of other residents within the facility was completed; no other residents are noted to have a preference for assistance with personal cares. If a preference is newly identified, it will be documented within the residents careplan. Staff responsible for assisting residents with personal cares re-educated on reading and following resident individualized care plan including resident preferences. Director of Nursing and/or designee will conduct audits of resident personal care careplans and complete random staff interviews to confirm that resident preferences are being honored. Audits will be completed weekly x3 weeks then monthly until the next Quality Assurance Committee; results of the audits will be reviewed with the members of the QA committee to determine the appropriateness/frequency of ongoing assessments.	

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F 561	Continued From page 3 participate as able. hair shampoo and nail care per staff, requests no male caregivers. Meadow care sheet dated 4/23/23, indicated R16 no male caregivers for personal cares. R16's progress note dated 3/12/23, at 6:19 p.m. nursing assistant (NA)-A indicated R16 was verbally upset and told writer that she did not want males to do her showers. Resident appeared very down and uncomfortable and stated that she "never wanted to do a shower again." Writer notified RN on shift and RN stated she would be working tomorrow morning and would address it and take appropriate measures. Resident had stated that nothing bad happened but that she just prefers females instead of males and that "this facility should only have females with females and males with males." On 4/24/23, 1:47 p.m. during an interview R16 indicated yesterday a male staff assisted with the bath and R16 verbalized she had made the facility aware previously she didn't want males assisting with baths and personal cares. R16 further indicated when a male assisted her she did not refuse or voice her preference as she had already voiced her preference to someone at the facility. R16 further discussed she doesn't want people to think wants to be in charge. On 4/25/23, at 8:39 a.m. NA-B indicated males or females were able to assist R16 with personal cares. On 4/25/23, at 9:47 a.m. registered nurse (RN)-A indicated R16's preference of no male caregivers was indicated on R16's care plan and the care sheets, and RN-A indicated staff were expected	F 561		

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F 561	Continued From page 4 to utilize the caresheets and care plans for specific resident information. RN-A verified R16 was not expected to receive personal cares with male staff. On 4/25/23, at 12:12 p.m. during an interview NA-C previously assisted R16 with a bath and became aware of R16's preference for no male assistance after he assisted R16 with the bath. NA-C stated the information specific to caregiver preference was in R16's care plan, and indicated had only assisted R16 with one bath. On 4/25/23, at 1:05 PM during an interview with RN-A and director of nursing (DON) indicated document review revealed R16 received a bath 3/12/23, assisted by NA-C,a male caregiver, 3/26/23, and 4/23/23, assisted by NA-D, described as a male caregiver. During the interview RN-A indicated on 3/10/23, only females caregivers were implemented on R16's care plan and care sheets, and staff were expected to utilize the caresheets every shift. On 4/25/23, at 1:35 p.m. during an interview R16 indicated when a male assisted her at the facility with personal cares, she did not feel comfortable telling males she did not want care from them and expected the facility to ensure she only had female care givers for her personal hygiene as she voiced this concern. R16 stated Sunday (4/23/23), one male and one female caregiver assisted her with her bath and she was not comfortable with males during personal hygiene, and stated the males were not doing anything wrong its her comfort and embarrassment with males seeing her during personal hygiene. On 4/25/23, at 1:38 p.m. during an interview the	F 561		

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F 561	Continued From page 5 DON confirmed the documentation of R16's baths with males, the schedule reflected only male staff were scheduled on R16' s hallway. The DON confirmed dates R16 received a bath males were assigned to R16, however the DON indicated staff were expected to ensure resident's choices of no males was honored. Facility policy titled Ridgeview LeSuer Medical Center family of Health Services and Living Options, dated 2/22, indicated; At Ridgeview LeSuer Nursing & Rehab Center encourage residents to make choices and decisions. The resident's combined federal and state Bill of Rights list self-determination and participation as having their right to choose activities schedules and healthcare; interact with members of their community; and make choices about aspects of their life in the facility that are significant to them. Facility policy titled Activities of daily living (ADLs), dated 12/31/22, indicated: Purpose: To provide residents with care treatment and services appropriate to maintain or improve their ability to carry out activities of daily living. Policy: Residents unable to carry out ADL 's independently or receive the services necessary to maintain good nutrition, grooming, personal hygiene, elimination, communication and mobility. Implementation: 1. Care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (Bathing, dressing, grooming, and	F 561		

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F 561	Continued From page 6 oral care) 5. The residents responses to interventions will be documented, monitored, and evaluated and revised as appropriate.	F 561		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 661	R25 discharged from the facility on	6/1/23

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F 661	Continued From page 7 facility failed to ensure appropriate discharge medication instructions were provided and documented to ensure continuity of care and reduce the risk of post-discharge complications for 1 of 1 resident (R25) reviewed for discharge practices. Findings include: R25's discharge return not anticipated Minimum Data Set (MDS), dated 2/13/23, identified R25 had severe cognitive impairment, required limited assistance with bed mobility, transfer; extensive assistance with walk in room, dressing, toilet use, personal hygiene; diagnoses included diabetes, muscle weakness, hypertension (high blood pressure), visual loss, heart failure, dementia, and Alzherimers disease. R25's discharge care conference/plan of care document dated 2/13/23, registered nurse (RN)-A indicated R25 was discharging to assisted living (AL), discharge date 2/13/23, the medications section indicated: see attached sheet for medications and instructions, and the section pharmacy name and telephone number was left blank and not completed. Order communication form dated 2/8/23, signed by Nurse Practitioner (NP) on 2/8/23, indicated discharge R25 to AL on current meds and treatments with PT/OT (physical therapy/occupational therapy) for mobility transfer in new environment. Progress note dated 2/13/23, at 12:21 p.m. RN-A indicated reviewed discharge paperwork with family member (FM)-C, paperwork signed by FM-C and copies sent with, left via family car to	F 661	2/13/23, it is no longer appropriate or timely to provide discharge medication instructions. Review of facility discharge process indicates that resident discharge medication instructions was being completed for residents discharging from the facility, except residents discharging to assisted living facilities. The facility will now complete discharge medication instructions for all planned discharges, regardless of discharge location. Facility nursing leadership education on the need for discharge medication instructions to be reviewed with all resident discharges. Director of Nursing and/or designee will conduct audits of resident discharge charts to ensure discharge medication instructions are completed. Audits will be completed weekly x3 weeks then monthly until the next Quality Assurance Committee; results of the audits will be reviewed with the members of the QA committee to determine the appropriateness/frequency of ongoing assessments.	

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F 661	Continued From page 8 AL. Progress note dated 2/13/23, at 9:40 a.m. indicated R25 will be discharging to (assisted living), R25 and family are in agreement with this plan, FM-C will be picking R25 up for discharge around 11:30 a.m. today (2/13/23), R25 provided with notice of transfer/discharge, no further questions or concerns. R25's medical record was reviewed and lacked evidence R25's medication administration history, including last provided doses or when doses were next due, had been reviewed prior to R25's discharge. On 4/26/23, at 2:18 p.m. during an interview the director of nursing (DON) indicated R25's current med list was printed and provided to the discharging AL facility. The DON indicated a current discharge summary along with current medications was reviewed when residents discharged to an assisted living however, current practice did not include a medication reconciliation, that compared pre-discharge and post-discharge. Facility policy titled Discharge Summary Policy and Procedure, dated 2/23, indicated: Policy: It is the policy of Ridgeview Le Sueur Nursing and Rehab center that residents who have a planned discharge from the facility will have a completed discharge plan and recapitulation of stay completed to facilitate continuity of care after discharge. Post-discharge continuity of care is well known to improve health outcomes for discharge residents and help prevent readmissions to the hospital. While the	F 661		

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(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 661	Continued From page 9 health care system searches for a computer based solution to inform sharing challenges, facilities must continue to provide relevant information about discharging residents to their care providers and to the residents and representatives. C. Medication reconciliation will be completed comparing pre-discharge and post-discharge medications, including over the counter and prescribed medications. -provide listing or medications per order, correlating diagnosis and education as indicated. -notify the attending provider for clarification of medication orders if there is a discrepancy identified in the reconciliation, prior to releasing post-discharge medication information 4. retain the discharge summary in the resident's medical record.	F 661		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ...	F 676		6/1/23

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	245416	A. BUILDING _____ B. WING _____	C 04/26/2023

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F 676	Continued From page 10 §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document review the facility failed to ensure activities of daily living (ADLs) of weekly baths were provided for 1 of 2 residents (R16) who needed assistance with bathing. Findings include: R16's admission Minimum Data Set (MDS) assessment dated 2/8/23, indicated R16 admitted to the facility on 2/2/23, had moderate impaired cognition, no rejection of care, required two person physical assist with bed mobility, transfer, toilet use, and personal hygiene; one person physical assist with dressing, eating, locomotion on and off unit, utilized a wheelchair, diagnoses	F 676	R16 has discharged from the facility since the survey exit. A review of resident careplans completed to assure residents have a scheduled bath. Residents will be offered/provide weekly baths. Resident's baths will be documented within the resident's medical record. Education was provided to staff responsible for providing cares on the need to provide and document resident cares including weekly baths. Director of Nursing and/or designee will	

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F 676	Continued From page 11 included: hip fracture, malnutrition, fracture of left femur (thigh bone), delirium, peripheral vascular disease (blood circulation disorder), and anemia (low number of red blood cells). R16's care plan revised 4/7/23, indicated alteration in self care r/t (related to) non displaced subtrochanteric l (left) femur fx (fracture) as e/b (evidenced by) her non wt (weight) bearing status and need for assistance with her ADL's (activities of daily living), also had delirium issues at the hospital that impacted her ability to provide her own cares, delirium has improved, 3/7/23-wt bear as tolerated and approach included: a-1 (assist of one) to dress/undress upper/lower body, encourage to participate as able, staff pull up pants and put socks/shoes on/off, personal hygiene: able to wash/dry face/hands, comb hair, apply deodorant/lotion, may need more assistance when distracted and having difficulty following directions, bathing: a-2 (assist of two) with slide board with transfers in/out of shower; a-1 to wash/dry upper/lower body, encourage to participate as able. hair shampoo and nail care per staff, requests no male caregivers. R16's Point of Care ADL Category Report dated 2/6/23-4/25/23, indicated R16 received a shower on 4/23/23, 4/10/23, 3/26/23, 3/12/23 and R16's record review failed to indicate any baths during February 2023. Document titled Meadow/Bluff bath record indicated R16 had scheduled baths Tuesday evenings. On 4/24/23, at 1:52 R16 indicated on Sunday (4/2/23) a shower was provided, after she requested the shower, and R16 further indicated	F 676	conduct audits of resident medical records and/or resident interviews to ensure residents are receiving their weekly bath. Audits will be completed weekly x3 weeks then monthly until the next Quality Assurance Committee; results of the audits will be reviewed with the members of the QA committee to determine the appropriateness/frequency of ongoing assessments.	

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F 676	Continued From page 12	F 676		

otherwise would have not received a shower. R16 stated she wanted shower once a week, and the showers were inconsistent. R16 further discussed the showers used to be weekly, and was unaware of her scheduled shower day. R16 indicated the facility falls behind on the resident's showers and then the days changed.

On 4/25/23, at 9:47 a.m. registered nurse (RN)-A indicated staff were expected to utilize the caresheets and care plans for specific resident information.

On 4/25/23, at 12:12 p.m. during an interview NA-C previously assisted R16 with a shower.

On 4/25/23, at 1:05 p.m. during an interview with RN-A and the director of nursing (DON) stated document review indicated R16 had no documented baths or showers during February 2023. The DON indicated did not think the documentation was accurate of R16 only having four baths since admission, and more of a documentation issue then the resident not receiving her bath. The DON and RN-A confirmed the documented baths were 4/23/23, 4/10/23, 3/26/23, 3/12/23.

On 4/25/23, at 1:35 p.m. R16 further voiced she did not receive scheduled regular baths or showers, and indicated she requested female staff assistance with showers weekly to the facility staff.

Facility policy titled Activities of daily living (ADLs), dated 12/31/22, indicated:

Purpose: To provide residents with care treatment and services appropriate to maintain or improve

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F 676	Continued From page 13 their ability to carry out activities of daily living. Policy: Residents unable to carry out ADL 's independently or receive the services necessary to maintain good nutrition, grooming, personal hygiene, elimination, communication and mobility. Implementation: 1. Care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (Bathing, dressing, grooming, and oral care) 5. The residents responses to interventions will be documented, monitored, and evaluated and revised as appropriate.	F 676		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure appropriate precautions and supervision was provided to reduce the risk of accidents or injuries for 1 of 1 resident (R19) who sustained a foot injury when he left the facility for an appointment without staff supervision.	F 689	R19 is encouraged to use medical transportation for appointments as available. If medical transportation is not available, education will be provided to the individual accompanying R19 to the appointment to assure the individual is aware of appropriate safety precautions to take to reduce the risk of accidents or	6/2/23

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F 689	Continued From page 14 Findings include: R19's face sheet printed on 4/26/23, indicated diagnoses of fracture of great toe, right foot (result of injury sustained on 4/17/23), cerebral infarction (stroke), hemiplegia affecting right dominate side (paralysis of right side of the body), aphasia (loss of ability to understand or express speech) following cerebral infarction, diabetic neuropathy (nerve damage that affects the legs and feet), and obesity. R19's quarterly Minimum Data Set (MDS) assessment dated 1/16/23, indicated R19 had moderately impaired cognition. R19, who didn't walk, required extensive assistance of one or two staff for all activities of daily living (ADL's) except eating. R19's care plan did not address transportation to appointments. A provider note dated 4/19/23, indicated R19's weight at 144 kg (kilograms) or 317 pounds. An accident/incident report completed by transit driver (TD)-E, dated 4/17/23, indicated an incident occurred at 1:00 p.m. in which, while on the lift as R19 was getting loaded into the bus, his toe/toes were pinched in the plate that folds up at the end of the lift. R19 was wearing socks with no shoes. Non-employee witnesses included family member (FM)-F and (FM)-G. Progress note dated 4/17/23, at 9:09 p.m., indicated a little after 4 p.m., registered nurse (RN)-B was called to assess R19, as it had been reported R19's foot had been pinched in the van when out for an appointment. RN-B noted that	F 689	injuries while out of the facility. All residents that require assistance with transportation have the potential to be impacted in a similar manner, thus the facility will encourage the use of medical transportation for appointments when available. If medical transportation is not available and/or is refused, the facility will provide education to individuals accompanying and/or providing safe transportation on general safety precautions to reduce the risk of accident or injuries. The facility policy/procedure will be revised. Facility staff that assist in coordinating transportation for appointments will review the updated policy. Director of Nursing and/or designee will conduct audits of resident appointments to ensure transportation was provided by medical transportation or provided education on on safe transportation and general safety precautions to reduce the risk of accident or injuries . Audits will be completed weekly x3 weeks then monthly until the next Quality Assurance Committee; results of the audits will be reviewed with the members of the QA committee to determine the appropriateness/frequency of ongoing assessments.	

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F 689	Continued From page 15	F 689		

R19's right foot was very swollen as well as his right lower leg. RN-B obtained an order to send R19 to the emergency room for evaluation. RN-B asked R19 if his foot had been run over by his wheelchair and R19 nodded yes. RN-B asked R19 if his foot had been pinched in the van, he shook his head no.

Progress note dated 4/17/23, at 9:14 p.m. indicated in part: ...it was reported by nursing assistants that they had seen R19's foot being run over by his wheelchair when returning from appointment. R19 returned from the emergency room with diagnosis of closed, non-displaced fracture of distal phalanx (long bone in foot) of right great toe.

Radiology report of three views of right foot, dated 4/17/23, indicated R19 had non-displaced fracture present in the distal phalanx of the first toe and marked soft tissue swelling in the mid-foot.

Progress note dated 4/18/23, indicated RN-B spoke to the transit company regarding the incident, who stated they had to take R19's footrests off (his wheelchair) to be able to get his wheelchair onto the lift as they were too close to the ground. R19's feet had been dragging on the ground at that time. When the driver started lifting the ramp up to be able to get R19 into the van, his foot got caught in the ramp.

During an interview on 4/24/23, at 2:30 p.m., nursing assistant (NA)-E stated that on 4/17/23, while walking toward the facility to work the afternoon shift, she witnessed FM-F pushing R19 in his wheelchair, while FM-G was pulling the wheelchair, holding onto an armrest. NA-E stated

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F 689	Continued From page 16	F 689		

the footrests were on the wheelchair, but R19's right foot had fallen off the footrest and was being flexed under the wheelchair and R19 was hollering out.

During an interview on 4/25/23, at 10:41 a.m., the director of nursing (DON) stated the ride company got R19's foot caught in the door or the lift, and that the social worker (SW)-A had conducted the investigation.

During a telephone interview on 4/25/23, at 11:48 a.m., TD-E stated another driver had taken R19 to the dentist on 4/17/23, and she brought R19 back to the facility. TD-E stated the local transit service was public transportation, not medical transportation, adding drivers were not trained to assist patrons so they either had to have someone accompany them or transfer themselves. When TD-E arrived at the dental office with the bus, FM-F wheeled R19 out of the building to the parking lot. TD-E observed R19 wasn't wearing shoes, only socks. TD-E stated the wheelchair was extra-long and wouldn't fit on the platform between the front and back plates, so she determined the footrests had to come off. Since TD-E wasn't trained to do this, FM-F and FM-G removed the footrests and then FM-F pushed R19's wheelchair onto the platform of the lift. Once R19 was on the platform facing the bus, TD-E raised the platform, stating when the platform is raised, approximately four-inch-tall metal flaps go up on the front and back side of the platform to prevent the wheelchair from rolling off the platform. When the platform levels with the bus, those flaps go down and another flap goes on top of it to create a ramp to roll the wheelchair into the bus. When that flap came down, it came down on R19's right foot, causing R19 to holler

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F 689	Continued From page 17 out. TD-E stated the flap was metal and squeezed R19's foot for maybe a second or two before TD-E lowered the platform to release the flap. Prior to the platform going up, TD-E, FM-F and FM-G had not realized R19's legs and feet were not clear of the flap. FM-G went inside the bus and pushed R19's legs back closer to the wheelchair, then TD-E resumed the process. TD-E stated this was the first time R19 had been transported with this transport service. TD-E stated that compared to other patrons, R19 was a big guy with a big wheelchair that was wider and longer than most. TD-E stated FM-F seemed to struggle to push R19's wheelchair to the bus and onto the platform because of the effort it appeared for him to propel the wheelchair forward. Once they arrived at the facility and R19's wheelchair was unloaded in the parking lot, FM-F and FM-G put the footrests back on the wheelchair. TD-E did not observe anything more as she drove away. During an interview on 4/25/23, at 1:00 p.m., SW-A stated she along with the DON had been notified of the incident on the evening of 4/17/23, and she started an investigation the next day. As part of the investigation, SW-A stated she spoke to NA-E who witnessed the incident. NA-E told SW-A that from a distance, she could see FM-F and FM-G attempting to bring R19 into building and could see they were struggling. NA-E heard FM-G say to FM-F, stop - you're running over his foot. SW-A stated she spoke briefly to FM-G on 4/18/23, and FM-G told SW-A that the transit company clamped R19's foot in the ramp. In addition, SW-A spoke to the manager of the transit service who said they would be conducting their own internal investigation. SW-A did not speak directly to the driver who transported R19	F 689		

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F 689	Continued From page 18 on the day of the incident. In addition, SW-A did not interview FM-F and FM-G to ask for their detailed account of what took place. SW-A acknowledged public transportation was likely not an appropriate mode of transportation for R19 due to his size. When asked what interventions had been put into place to prevent future occurrence, SW-A stated they likely would not use that kind of transportation going forward. During an interview on 4/25/23, at 1:39 p.m., with (RN)-A and SW-A, when asked what interventions had been put in place to prevent future occurrence, RN-A stated they discussed having staff go with R19 next time but admitted that intervention had not been added to R19's care plan. SW-A admitted as part of their investigation no one had talked directly to the transit driver for a first-hand account of the incident. SW-A stated her interpretation was that the [toe] fracture occurred by the transportation company when R19's foot was pinched. RN-A and SW-A admitted that the cause of R19's fracture could have occurred when his toe was pinched in the bus, or it could have occurred when FM-F an FM-G wheeled R19 into the building and his right foot was flexed underneath the wheelchair. SW-A and RN-A admitted the latter had not been considered. During an interview on 4/25/23, at 2:04 p.m., FM-G stated FM-F and FM-G met R19 at the local dental office on 4/17/23. When the appointment was done, FM-F took R19 to the transit bus in the parking lot and removed the legs from the wheelchair. Once the platform was raised, R19's toe got caught in a flap and R19 hollered out. FM-G stated the driver put the flap down and she (FM-G) pushed R19 back a bit to	F 689		

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F 689	Continued From page 19 get his toes out of the way. When they got back to the facility, FM-G told a nurse what happened. When asked about wheeling R19 into the building from the parking lot, FM-G stated she and FM-F put the footrests back on R19's wheelchair and wheeled him into the building. FM-G denied having difficulty wheeling R19 in the parking lot or up the low-grade incline into the main entrance, and also denied R19's foot fell off the footrest and got flexed under the wheelchair. During an interview on 4/25/23, at 3:53 p.m., NA-E was interviewed again due to discrepancy between NA-E's earlier account of the incident and FM-G's account of the incident. NA-E stated both she and trained medication aide (TMA)-A witnessed the incident, and both gave verbal statements. NA-E stated she observed FM-F pushing R19's wheelchair and FM-G pulling the wheelchair and heard R19 holler. NA-E heard FM-G yell, stop, his foot is under the wheel. NA-E stated she observed R19's right foot was not on the footrest, then observed FM-G put it back on the footrest. NA-E stated it was difficult to maneuver R19 in his wheelchair due to his weight. NA-E stated she would feel comfortable getting R19 onto local public transportation via wheelchair but would need to see it [the bus] first, adding she didn't know if just one person could do it. During an interview on 4/26/23, at 7:49 a.m. with the DON and SW-A, the DON stated after the incident, leadership talked through what happened and spoke to witnesses NA-E and TMA-A on the phone. When asked what interventions had been put in place to prevent future occurrence, the DON stated they would send staff with R19 on future appointments. The	F 689		

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F 689	Continued From page 20 DON admitted the intervention did not identify the type of staff (clinical or non-clinical). When asked about staff training to accompany R19 on public transportation, the DON stated she thought staff would feel comfortable maneuvering R19's wheelchair onto the transit bus despite his weight and large and heavy wheelchair. The DON admitted there had been no plan to train or orient staff to this role. The DON and SW-A were informed of the concern of lack of staff oversight for R19's safety on public transportation on 4/17/23. Neither the DON or SW-A viewed R19's weight and size of his wheelchair a barrier for a family member to maneuver safely, however the SW-A acknowledged the situation didn't go well. During an interview on 4/26/23, at 8:27 a.m., regarding the intervention after this incident, the DON stated "staff" meant a nurse or aide but admitted this had not been specified. The DON admitted the care plan had not been updated after the incident to identify a nurse or aide would need to accompany R19 on public transportation. The DON didn't know who made the decision to select medical or public transportation for residents, adding for most transports, it was whatever was available. The DON did not know if the facility transport scheduler and nursing collaborated regarding safest mode of transportation and/or if/when staff needed to accompany a resident. During an interview on 4/26/23, at 8:52 a.m., health information specialist (HIS)-H stated she arranged transportation for resident appointments. When determining the type of transportation, public or medical, HIS-H stated she asked the family. HIS-H stated R19 had to be transported on a handicapped bus, and for local	F 689		

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(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 689	Continued From page 21 appointments, that would have to be public transportation. HIS-H explained that for in-town appointments, public transportation was used if the family could not take the resident in a private vehicle. Further, HIS-H stated medical transport companies would not come into town for an in-town appointment, so that was not an option for R19. During a telephone interview on 4/26/23, at 10:07 a.m., TMA-A stated she observed FM-F and FM-G taking R19 into the building on 4/17/23. TMA-A stated FM-F was pushing R19's wheelchair from behind and FM-G was walking along side. TMA-A heard R19 holler, and while FM-F was still pushing the wheelchair, heard FM-G holler, "Wait, Wait -- his foot." TMA-A then observed FM-G pick up R19's foot and put it on the footrest, adding that it must have fallen off the footrest at some point. TMA-A stated it appeared FM-F was frustrated...when the entrance door to the facility automatically opened, it started to close before FM-F could get through with R19, so he shoved open the door real hard. In addition, TMA-A observed FM-F pushing R19's wheelchair toward the entrance. TMA-A stated R19 was heavy...stating she had pushed him in that wheelchair before, stating...it's a heavy wheelchair and he's a heavy guy. When asked if she would feel comfortable loading and unloading R19 into the transportation bus if staff were needed to accompany him, TMA-A stated, yes, but I would prefer someone else do it -- it's so heavy, you literally have to bend your back to get a start forward. During an interview on 4/26/23, at 12:27 p.m., patient account representative (PAR)-J stated she was filling in for HIS-H and had arranged	F 689		

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	245416	A. BUILDING _____ B. WING _____	C 04/26/2023

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MINNESOTA VALLEY HEALTH CENTER INC	621 SOUTH 4TH STREET LE SUEUR, MN 56058

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F 689	Continued From page 22 transportation for R19's dental appointment on 4/17/23. PAR-J stated RN-A had informed her R19 needed transportation and that FM-F and FM-G would accompany him. During an interview on 4/26/23, 3:05 p.m., findings were reviewed with the DON and administer, including identified concerns that the facility did not individualize the needs of R19, who was obese and had a large and heavy wheelchair, for safe transfer on public transportation. In addition, following the incident, a thorough investigation including interviews of all parties involved, including TD-E, FM-F and FM-G, had not been done. Moreover, the intervention put in place following the incident did not specify how R19 would be kept safe in the future, other than sending staff along on future appointments. The intervention did not specify what type of staff, such as clinical or non-clinical. Further, there was no plan for staff orientation or training to the transit bus given staff would be solely responsible for maneuvering R19 on uneven, outside terrain, and safely getting R19 on and off the platform of the bus since local public transit staff were not trained to provide this service. The administrator acknowledged not being aware of some of these findings, however both the DON and administrator believed an appropriate transfer was arranged for R19 on 4/17/23, and a thorough investigation had been conducted. Facility policy titled Non-emergency Transportation Guidelines, with revised date of 10/13/22, was geared more for an acute care facility and did not address safety measures for public transportation for long term care residents who needed assistance.	F 689		

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F 689	Continued From page 23 Facility policy titled Safe Patient Handling, revised date of 1/9/23, was geared more for an acute care facility and did not address how staff would safely manage residents out of doors on uneven terrain and loading into a public transportation vehicle.	F 689		
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a registered nurse (RN) was on duty for at least eight consecutive hours per day for seven days a week. This had the potential to affect resident assessments, care, and treatments for all 23 residents in the facility. Findings include: During an interview on 4/25/23, at 2:54 p.m. with staffing coordinator (SC)-A, reviewed process for completing nursing staff schedules. SC-A indicated a RN was scheduled for eight hours	F 727	The facility's "Nursing and Rehabilitation Center's Nursing, Staffing and Attendance Policy" was revised to address the requirement to schedule an RN for at least 8 consecutive hours a day, seven days a week. The daily nursing schedule form was updated to document the RN in the building for 8 consecutive hours. Facility leadership and scheduling assistant have reviewed the revised policy. The Director of Nursing and/or designee	5/31/23

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F 727	Continued From page 24 each day, and if not, a RN such as director of nursing, nurse manager or MDS (Minimum Data Set) nurse would be on-call from home. During an interview on 4/25/23, at 4:45 p.m., the director of nursing (DON) acknowledged there was an RN on duty in house for eight consecutive hours each day, seven days a week. Reviewed nursing staffing posting sheets and nursing staff schedules for February, March and April 2023. The nursing staff schedules for Saturday 4/8/23, and Sunday 4/9/23, did not have a RN scheduled on duty in house. (RN)-B was listed at the bottom of the schedule as being on-call. On the nursing staffing posting sheets for Saturday 4/8/23, and Sunday 4/9/23, the RN hours were crossed out. During an interview on 4/26/23, at 1:46 p.m., with the DON and SC-A, the DON acknowledged that on 4/8/23, and 4/9/23, there was not an RN scheduled to be in house for eight consecutive hours. The DON stated they were counting the RN from the previous day, who was scheduled the 10 p.m. to 6:30 a.m. shift, since the majority of his/her hours were on the following day. Facility policy titled Nursing and Rehab (rehabilitation) Center, Nursing Staffing and Attendance, with revised date of 2/22/23, outlined the scheduling process and rules, but did not address the requirement to schedule an RN at least eight consecutive hours a day for seven days a week.	F 727	will audit the weekly schedule to assure the RN coverage requirement is met. Audits will be completed weekly x3 weeks then monthly until the next Quality Assurance Committee; results of the audits will be reviewed with the members of the QA committee to determine the appropriateness/frequency of ongoing assessments.	
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2)	F 919		6/1/23

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F 919	Continued From page 25 §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure resident bathroom call light cords were within reach from the bathroom floor for 3 of 3 residents (R1, R2, R21), reviewed for call lights. Findings include: R1 R1's annual Minimum Data Set (MDS) assessment dated 4/17/23, included diagnoses of arthritis and weakness. R1 had moderate cognitive impairment and required extensive assistance of two staff for transfers and toileting. During an interview and observation on 4/25/23, at 8:30 a.m., along with licensed practical nurse (LPN)-A, observed the bathroom wall-mounted call light device had no cord attached to it. The device was approximately three to four feet from the floor. LPN-A stated instead of pulling a cord, R1 could press the button on the device, and pointed to the large round button in the middle of the device . LPN-A admitted if R1 was on the floor, he would not be able to reach the call light for assistance. R2 R2's quarterly MDS assessment dated 4/2/23,	F 919	All bathroom emergency pull cords have been replaced to meet the requirement and will be no shorter than 4 inches from the floor. The requirement for bathroom emergency cords to be accessible from the floor will be reviewed in the facility safety meeting. Nursing staff were educated that if they observe a bathroom call light that does not have a cord or if the cord becomes damaged and needs to be replaced to immediately report it, so that the cord can be replaced for the call light to be accessible from the floor. A monthly inspection has been entered into the facilities work order system to prompt for an inspection of resident bathrooms to ensure the call light cord remains in place and is accessible from the floor. Facilities management and/or designee will perform and document an annual preventative maintenance check of all call light pull cords.	

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F 919	Continued From page 26 included diagnoses of cerebral palsy (disorder of movement, muscle tone or posture) and hemiplegia (paralysis of one side of the body) following cerebral infarction (stroke). R2 had moderate cognitive impairment and required extensive assistance of two staff for transfers and extensive assistance of one staff for toileting. During an observation and interview on 4/24/23, at 11:55 a.m., observed R2's bathroom call cord about 18 inches from the floor. R2 stated she used the bathroom and pulled the call light cord when she was finished. R21 R21's quarterly MDS assessment dated 3/24/23, included diagnoses intracerebral hemorrhage (ruptured blood vessel causing bleeding in the brain) and history of falling. R21 had severe cognitive impairment and required limited assistance of one staff for transfers and toileting. During an observation and interview on 4/24/23, at 1:03 p.m., observed R21's bathroom call cord about 18 inches from the floor. R21 stated he toileted himself independently. During an interview on 4/25/23, 7:55 a.m., maintenance manager stated he was not aware of regulation pertaining to the length of call cords in bathrooms, adding most of the call cords would not be to the floor. During an interview and observation on 4/25/23, at 8:26 a.m., along with facilities engineer, he verified the call light cord in R21's bathroom was 17 inches from the floor and in R2's bathroom, was 18 inches from the floor.	F 919		

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F 919	Continued From page 27 Facility policy regarding resident call light cords was requested and not received.	F 919		
F 921 SS=C	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions 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 equipment in the kitchen was clean. Finding include: On 4/24/23, at 10:40 a.m. during the initial kitchen tour with dietary manager (DM) the dish room was observed with a fan attached to the wall and blew on clean dishes; included silverware and serving bowls. The fan and fan blades had gray debris and fuzz that blew on the clean dishware. The DM indicated the fan assisted with drying of the dishes. The DM confirmed the fan was dirty and was not expected to blow on clean dishware, and staff were expected to remove or clean the fan when dirty. The DM was unable locate documentation of the fan cleaning. On 4/25/23, at 11:10 a.m. during an observation in the clean dishware of the kitchen a fan with gray debris, fuzz and lint particles attached to the wall, blew on clean dishware drying. 04/25/23 11:12 a.m. interview with the cook (C)-A indicated the fan assisted in drying the clean dishes and stated the fan was expected cleaned	F 921	The fan has been removed from the kitchen and the dishes will air dry per the facility Nutrition Services Infection Control Policy. Education provided to nutrition services staff that fans are not permitted in the kitchen environment. Nutrition Services Manager and/or designee will complete random audits to assure that there is no fan present in the kitchen environment. Audits will be completed weekly x3 weeks then monthly until the next Quality Assurance Committee; results of the audits will be reviewed with the members of the QA committee to determine the appropriateness/frequency of ongoing assessments.	5/26/23

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F 921	Continued From page 28 monthly, and confirmed the fan was not clean. Facility policy titled Procedure/Guideline: Nutrition Services Infection Control, dated 4/21, indicated Purpose: To provide guidelines and support for infection control practices in the kitchen, cafeteria, and other food handling areas. -The items should be immersed in this water for at least 30 seconds after which they should be placed on the counter or drying rack. Toweling is not acceptable and all containers and utensils should be air dried.	F 921		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/25/2023. At the time of this survey, Minnesota Valley Health Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 05/23/2023

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Minnesota Valley Health Care is a 1-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1967 and was determined to be of Type II(111) construction. In 1996, addition was constructed to the East Wing that was determined to be of Type II(111) construction Because the original building and addition meet the construction type allowed for existing	K 000		

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K 000	Continued From page 2 buildings, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and resident rooms, that is monitored for automatic fire department notification. The facility has a capacity of 55 beds and had a census of 21 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual	K 923		5/26/23

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K 923	Continued From page 3 cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain oxygen cylinder storage per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 11.6.5.2 and 11.6.5.3. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 04/25/2023 at 12:15 PM, it was revealed by observation that oxygen cylinders in the oxygen storage room were not separated and marked empty or full. An interview with the Maintenance Director verified this or these deficient finding(s) at the time of discovery.	K 923	Facilities manager added additional e-tank cylinder cradles to the oxygen storage room and appropriate signage identifying the a set of cradles as 'empty' and another set of cradles as 'full'. Education was provided to staff on the appropriate storage and separation of 'empty' and 'full' oxygen tanks. Facilities manager and/or designee will complete observation audits to verify oxygen tanks are appropriately stored and separated. Audits will be completed weekly for three weeks then monthly until the next Quality Assurance Committee; results of the audits will be reviewed with the members of the QA committee to	

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K 923	Continued From page 4	K 923	determine the appropriateness/frequency of ongoing assessments.	