



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 7, 2025

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

RE: CCN: 245264
Cycle Start Date: June 25, 2025

Dear Administrator:

On June 25, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Stefanie Salberg, Regional Operations Supervisor
Metro C District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

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 September 25, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 25, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245264		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/24/2025	
NAME OF PROVIDER OR SUPPLIER APPLE VALLEY VILLAGE HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124			
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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on June 24, 2025, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Apple Valley Health Care, 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

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.

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

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OMB NO. 0938-0391

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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. Building Info: AUGUSTANA HEALTHCARE CENTER OF APPLE VALLEY is a three-story building, with a full basement The building was constructed in 1983 and was determined to be of Type II (222) construction, with a full basement. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with			K 000			

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K 000	Continued From page 2 full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 162 beds and had a census of 147 at the time of the survey.	K 000			
K 363 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other	K 363			

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K 363	Continued From page 3 materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/24/2025, at 9:30 AM, it was revealed by observation that the smoke control doors on the 1st floor by Room 121 and on the Lower Level by the Elevator failed to properly close. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K 363			

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E 000	Initial Comments On 6/23/25 to 6/25/25, a survey for compliance with CMS Appendix Z, Emergency Preparedness Requirements, was conducted during a standard recertification survey. The facility was found in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000			
F 000	INITIAL COMMENTS On 6/23/25 through 6/25/25, a standard recertification survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint were reviewed with no deficiencies cited: H52647537 MN00108959 H52647618 MN00108564 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 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 605	Right to be Free from Chemical Restraints	F 605			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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F 605 SS=D	Continued From page 1 CFR(s): 483.10(e)(1), 483.12(a)(2), 483.45(c)(3) (d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant;	F 605			

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F 605	Continued From page 2 (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented	F 605			

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F 605	Continued From page 3 in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure appropriate side effect monitoring for potential orthostatic hypotension (sudden drop in blood pressure what occurs when a person stands up after sitting or lying down) was completed for 1 of 5 residents (R79) reviewed for unnecessary medication use and who consumed antipsychotic medication. Findings include: A National Library of Medicine (NIH) Management of Commons Adverse Effects of Antipsychotic Medication article, dated 9/2018, identified the elderly were at risk of adverse effects (i.e., falls) of antipsychotic medication. The article outlined, "All antipsychotics carry some risk of orthostatic hypotension ... [which can] lead to dizziness, syncope, falls ... it should be evaluated by both history and measurement ... Risk factors include systemic diseases causing autonomic instability	F 605			

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F 605	Continued From page 4 (e.g., diabetes, alcohol dependence, Parkinson's disease), dehydration, drug-drug interactions, and age." R79's quarterly Minimum Data Set (MDS), dated 5/6/25, identified R79 had moderate cognitive impairment and demonstrated no hallucinations or delusional thinking during the review period. Further, the MDS recorded R79 consumed both antipsychotic and antidepressant medication(s). R79's View General Order, printed 6/25/25, identified a current nursing order which read, "Complete orthostatic blood pressure and pulse d/t use of antipsychotic medication," with a frequency listed, "Once a day on the 20th of Every 3rd Month." The order continued and listed instructions which read, "Enter lying, sitting, and standing BPs and Pulse under vital signs separately AND put in progress note," The order had a start date recorded, "11/20/2024." R79's Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 2/2025, identified R79's recorded medication administrations and treatments for the period. The MAR listed the nursing order to complete the orthostatic blood pressure and pulse, along with spacing to record data for these collected vital signs with a date of 2/20/25. However, only a single blood pressure was listed which read, "141/67," and the MAR lacked what position R79 was in when it was obtained (i.e., lying, sitting, standing). R79's corresponding Search Vital Results, dated 1/2025 to 6/2025, only recorded the same reading of, "141/67," on 2/20/25 and also lacked information on which position R79 was in when the reading was obtained.	F 605			

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F 605	Continued From page 5 R79's MAR and TAR, dated 5/2025, identified the same nursing order and spaces to record data for the collected vital signs with a date of 5/20/25. However, again, only a single blood pressure was listed which read, "125/60," and the MAR lacked what position R79 was in when it was obtained (i.e., lying, sitting, standing). R79's corresponding Search Vital Results, dated 1/2025 to 6/2025, only recorded the same reading of, "125/60," on 5/20/25 and also lacked information on which position R79 was in when the reading was obtained. On 6/24/25 at 1:52 p.m., registered nurse (RN)-C was interviewed, and verified they had worked with R79 prior. RN-C explained R79 was not ambulatory, however, he did transfer using a stand-by assist and did bear weight for them. RN-C stated R79 had some troubles with communication and often times wouldn't converse with staff adding, "He doesn't talk." RN-C stated R79 had not complained about dizziness or lightheadedness with transfers to their knowledge. RN-C explained orthostatic blood pressures were done only if ordered on the MAR or TAR, and expressed R79 did not have an order for them to their knowledge. RN-C reviewed R79's MAR in the medical record (June 2025) and stated it lacked direction to complete orthostatic blood pressures adding, "We don't have an order for that." RN-C stated they obtained R79's blood pressure earlier that day, on 6/24/25, and it had been 146/66 which RN-C stated "a little high" for him. R79's medical record, including progress notes, was reviewed and lacked evidence R79 had a complete set of orthostatic blood pressures			F 605			

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F 605	Continued From page 6 obtained or checked within the past several months, nor was there documented rationale for the lack of a complete set of them, despite R79 consuming antipsychotic medications. On 6/24/25 at 3:10 p.m., registered nurse unit manager (RN)-B was interviewed, and verified they had reviewed R79's medical record. RN-B stated R79 consumed Risperdal (antipsychotic) and they were unable to locate any complete sets of orthostatic blood pressures documented in the record for the past several cycles when due (i.e., Feb 25, May 25) adding aloud, "I did not [find any]." RN-B stated the floor nurses should be obtaining the orthostatic blood pressures and entering them into the medical record per the nursing order. RN-B reviewed R79's medical record and verified R79 transferred with a stand-by assist and expressed, "He does bear weight [with them]." RN-B stated staff should document rationale for why, if applicable, they were unable to complete the orthostatic blood pressures; however, again this was not found, either. RN-B stated R79 had sustained a few falls within the past several months, including during episode of self-transfers, and it was important to obtain orthostatic blood pressures as it was "in our policy" to do so and for "the best interest of the patient." When interviewed on 6/25/25 at 10:51 a.m., the director of nursing (DON) stated a complete set of orthostatic blood pressures should be obtained every 90 days and recorded in the medical record. DON stated they completed a house-wide audit of this process the day prior when the issue arose during survey and were working on potentially adjusting their "order set" to better capture the data. DON acknowledged R79 had	F 605			

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F 605	Continued From page 7 several falls within the past few months and expressed R79 seemed to "ebb and flow" with mobility adding, at times, he would be more mobile and anxious. DON verified they reviewed R79's medical record, including fall reports, and were unable to locate any orthostatic blood pressures being done or attempted since November 2024. DON reiterated they should be completed every 90 days in accordance with their policy on antipsychotic medication use which was developed in collaboration with their corporate pharmacy. This was important to do as the medication "can have a major effect on their blood pressure" and increase the risk of falls.	F 605			
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced	F 679			

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F 679	Continued From page 8 by: Based on observation, interview, and document review, the facility failed to ensure activities of interest were consistently offered, provided and documented within the medical record to support ongoing engagement and continuity of care for 2 of 2 residents (R58, R321) reviewed for activities and who resided on the transitional care unit (i.e., TCU). Findings include: R58 R58's admission Minimum Data Set (MDS, dated 6/7/25, identified R58 admitted to the care center on 6/2/25, and she had moderate cognitive impairment but demonstrated no delusional thinking during the review period. The MDS recorded under Section F - Preferences for Customary Routine and Activities that R58 felt it was "Very important" to do her favorite activities and keep up with the news; and she felt it was "Somewhat important" to have books, newspapers, or magazines and do things with group(s) of people. On 6/23/25 at 1:59 p.m., R58 was observed lying in bed while in her room. R58's eyes opened with audible interaction, and R58 stated she had been at the care center for "just about 24 hours" she thought. R58 had one visible, red-colored Word Search on her bedside dresser which was placed underneath various items such as other papers and a package of disposable wipes. R58's lacked any visible activities calendar on the wall. R58 stated she was not sure what, if any, activities she had been attending and expressed she "mostly rests" she thought. R58 stated she didn't	F 679			

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F 679	Continued From page 9 recall anybody offering to take her to activities but added she'd like to go to them, if offered, adding aloud, "Oh, of course!" R58 stated she enjoyed many activities prior to coming to the care center such as going for walks, light exercises, and reading and doing puzzles. R58's Therapeutic Activities Observation, dated 6/3/25, identified the evaluation as, "Initial Activities Assessment," and recorded R58 as having an anticipated length of stay as, "Less than 3 months." The evaluation recorded R58's demographic information (i.e., statistical data) and identified R58 as being Lutheran and attending services prior to admission. R58's preferred activities' program style was recorded as, "Large Groups," and "Independent leisure." The option reading, "One to One [1:1]," was left unchecked. A section labeled, "Describe resident's past interests," outlined R58 enjoyed participating in her senior community, playing board games, visits with family and watching television. The evaluation continued, "[R58] is interested in music entertainment, social events and attending worship services. Independent leisure interests include watching TV, reading books she has brought with her, and TP [therapeutic programming] library books, going outside with family when weather is good and family visits." The evaluation directed, "Initiate care plan." R58's corresponding Therapeutic Activities progress note, dated 6/3/25, identified staff met with R58 and welcomed her to the TCU. R58 was provided a community newsletter and "... TP Things To Do flyer." The staff recorded they answered questions about activities and outlined, "[R58] is here for short term rehab and has	F 679			

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F 679	Continued From page 10 interests in group and independent pursuits during his/her stay ... is interested in music entertainment, social events and attending worship services ... leisure interests include watching TV, reading books she has brought with her and TP library books ... " R58's activities care plan, initiated 6/22/25, identified R58 was at the care center for short-term rehab and, again, outlined her interests in group and independent leisure activities. The plan listed a goal which read, "Resident will participate in activities of choice," along with three interventions including, "Invite and remind of programs," and "Offer activity schedule." When interviewed on 6/24/25 at 1:31 p.m., nursing assistant (NA)-A stated they had worked with R58 prior and explained R58 needed help with transfers and most cares. NA-A was asked what, if any, group activities R58 attends and NA-A responded, "Therapy [PT/OT]." NA-A stated they had not observed R58 to attend any group activities or events while on the TCU and reiterated aloud, "PT/OT." NA-A stated the TCU did have a dedicated activities staff member; however, they were unsure of their name. NA-A stated R58 had never verbally complained about being bored to them, however, when asked how R58 seemed to spend their day when not with therapy NA-A responded aloud, "mostly nap and then watch the TV." R58's POC (Point of Care) History Report (3 Records), dated 6/2025 and provided by the therapeutic activities director (TAD), identified R58 had only three (3) activities recorded as being completed since admitting to the care	F 679			

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F 679	Continued From page 11 center on 6/2/25 (over 20 days prior). These were recorded as three separate 1:1's completed on 6/4/25, 6/12/25, and 6/16/25 with their length being 15 minutes, 40 minutes, and 10 minutes, respectively. The provided report lacked any evidence of what, if any, group-based activities (i.e., music, worship services) had been offered or attended by R58 despite these being identified as activities she was interested in. Further, R58's entire electronic medical record (EMR) was reviewed and lacked evidence R58 had been consistently invited, offered or attended any additional activities (including in-room activities like puzzles) outside of the three recorded 1:1 sessions since admitting to the care center. On 6/25/25 at 9:42 a.m., the TAD was interviewed and R58's POC History Report reviewed. TAD explained there were two people who assisted with activities on the TCU, and they visited residents upon admission to do an initial interview about their interests which is then recorded on an internal "checklist." The staff then review that checklist and compare it to which residents expressed interest in which type of activities to help determine who is invited to them. TAD reviewed R58's medical record and verified it outlined R58 expressed interest in music entertainment, social events, and attending worship services. However, TAD expressed only physically attended activities were recorded in the medical record (i.e., POC History Report) and there was no system to record offered and/or declined activities adding aloud, "Those are things that are not documented." TAD verified R58's medical record only have three 1:1 recorded since she admitted to the care center, and expressed a majority of residents on TCU were more therapy-focused instead of			F 679			

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F 679	Continued From page 12 activities-focused. TAD stated they had visited with their assistants on the TCU who expressed they had "stopped and talked to her [R58] multiple times" but, again, acknowledged these visits were not documented within the medical record. TAD stated R58 having three recorded 1:1 completed "seems good," and expressed if someone, including R58 or staff who work with her, had expressed concerns about R58 need "greater engagement" then they would have re-visited it with R58; however, nobody had ever reported concerns to the activities department to their knowledge. TAD explained each resident on the TCU was given a "community news" letter which had an included activities calendar. TAD reviewed the June 2025 calendar and verified it had multiple, scheduled music programs and social events listed on it since R58 admitted, however, again, TAD acknowledged none of these were recorded in the record as being offered or attended. TAD explained documenting offers to attend and refusals for activities were something that had "gone back and forth" with the corporate level but "their philosophy" was to solely document the ones attended adding, "The emphasis has not been on the refusals, [but] has been on the actual engagements." TAD stated the only 'proof' to show R58 was being offered activities was based on "word of mouth," and again expressed, "I don't have anything in writing." TAD acknowledged activities were important and expressed making sure residents were invited and attending them was important as "it's our mission to meet their needs." TAD added, "[Activities] helps their fullness of life." TAD then expressed they amended their process "recently" to do a routine 30-day follow-up note (i.e., progress note) on TCU residents where they review attendance and engagement; and from	F 679			

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F 679	Continued From page 13 this they could re-vise their care plan to ensure more activities involvement. TAD and the surveyor then reviewed a sample of other residents who had resided on the TCU since admission and had been present for over 30 days. A total of four (4) residents were reviewed and all of these lacked any completed 30-day note(s) in their record. TAD stated, "We may have missed some of them," adding further, "There's something going on with that process that doesn't seem to be happening." Later, on 6/25/25 at 12:43 p.m., TAD e-mailed the surveyor with a note, "I checked with my activity assistant and found she has some additional document about inviting residents to programs. It is not part of the medical record, but she keeps a notebook. Would you be interested in seeing it?" On 6/25/25 at 12:55 p.m., TAD and the activities assistant (TAA) were interviewed, and TAA explained they started keeping a notebook on their own accord as they had repeatedly had issues "hooking up" with residents for activities. TAA and the surveyor reviewed this notebook, which was a small, spiral top notebook that had columns written on the pages with included room number(s) along with days of the week outlined across the top. R58's room was located on these pages and identified a series of symbols (i.e., 'S' and 'O') which TAA explained in chronological order. This included: Week of 6/2/25 to 6/6/25 was reviewed. On 6/3/25 and 6/4/25, a handwritten, "N/I," was written which TAA stated meant R58 was not interested in activities. On 6/5/25, nothing was recorded, and the space was left blank. On 6/6/25, a handwritten, "w/ aide [NA]," was written. However, this notebook did not include	F 679			

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F 679	Continued From page 14 documentation or symbols to show the 1:1 which had been recorded in the POC History on 6/4/25; nor did the notebook outline if R58 was reproached about activities on 6/6/25. Week of 6/9/25 to 6/13/25 was reviewed. On 6/9/25 and 6/10/25, these dates each had a one symbol which looked like a circle with a line drawn through them. TAA explained these symbols meant they "didn't see them at all" that day, and verified they only checked once each day based on the symbols drawn. On 6/11/25, a symbol was recorded which was shaped like a checkmark; however, TAA could not recall what this meant. On 6/12/25, a handwritten, "Sleepin," was recorded and TAA verified they didn't check on R58 again based on the symbols drawn. In addition, again, this notebook did not include documentation or symbols to show the 1:1 which had been recorded in the POC History on 6/12/25. Week of 6/16/25 to 6/20/25 was reviewed. On 6/16/25, the space had four symbols of the circle with a line drawn through them on which, again, TAA explained meant they didn't see R58 on that day. Then, below those symbols, was handwritten text reading, "Very Confused 10 mon [sic; 1:1 per POC] visit Very Confused." On 6/17/25, the space had, "N/I," written along with two circles with a line through it and text reading, "Confused [and] Crabby." On 6/18/25, a circle with a line through it was drawn and, again, text reading, "Still Very Confused." On 6/19/25, one circle with a line drawn through it was present; and on 6/20/25 there was handwritten text reading, "Sleeping." The notebook lacked evidence R58 was reproached about activities on 6/19/25 or 6/20/25 based on the symbols drawn.	F 679			

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F 679	Continued From page 15 Week of 6/23/25 to 6/27/25 was reviewed. On 6/23/25, the space had another checkmark drawn along with writing, "[name] @ 2:00." On 6/24/25 and 6/25/25, the spaces were blank with nothing written or drawn. TAA verified the notebook didn't record any weekend activities, and stated such was because they didn't work weekends. TAA reiterated the notebook was made by themselves and had not been directed to be used. Further, TAA stated they rarely, if ever, woke people up for activities if they were found to be asleep at that time and expressed nobody from the care center (i.e., TAD or management) had ever told them to chart these attempts or refusals (i.e., N/I) in the medical record before. In total, between the POC History Report and the presented notebook, a total of only seven (7) times were recorded to prove R58 was provided an activity (i.e., 1:1) or directly offered an activity since her admission to the care center on 6/2/25 (23 days prior); and only three of these were recorded within the actual medical record. R321 R321's admission Minimum Data Set (MDS), dated 6/11/25, indicated R321 was cognitively intact, had no delusions or hallucinations, had no behaviors and did not refused cares. The MDS recorded under section F Preferences for Customary Routines and Activities, R321 felt it was "Very important" to do her favorite activities, participate in religious practices, and keep up with	F 679			

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F 679	Continued From page 16 the news; and she felt it was "Somewhat important" to have books, magazines to read, to do things with group of people, and to go outside to get fresh air when the weather was good. R321 Therapeutic Activities Observation dated 6/8/25, identified the evaluation as, "Initial Activities Assessment," and recorded R321 as having an anticipated length of stay as, "Less than 3 months." The assessment indicated R321 had current interest in pursuing leisure/activities and indicated R321 was interested in bingo, music entertainment, social events and attending Catholic services. The evaluation continued, R321's independent leisure interests included watching TV, going outside with family when weather was good, family visits, using her personal iPhone for streaming, games, internet searches and social media. Doing group activities, doing favorite activities, getting outdoors and participating in religious services/practices were categorized as very important or somewhat important. R321's Activities Care Plan dated 6/8/25, titled Outdoor Activity included: "Going outdoors is important for patient" indicated, R321 will remain safe when going outdoors evidenced by no accidents or injuries in the process. Care plan also indicated R321 was instructed to inform staff when going outdoors and was warned about sloped front parking lot, and that she may safely go outside with family assistance and supervision. In addition, care plan indicated if R321 attempted or requested to go outside alone, further safety screening may be needed. During interview on 6/23/25 at 3:15 p.m., R321 was sitting on a recliner and said she had been at			F 679			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/25/2025
NAME OF PROVIDER OR SUPPLIER APPLE VALLEY VILLAGE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124		
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F 679	Continued From page 17 the facility since 6/6/25. R321 stated she was not aware if the facility had any activities, and added "Nobody has mentioned anything about activities" and had not been invited to go to an activity. R321 further stated, "I do not have an activity schedule in my room." During interview on 6/24/25 at 12:53 p.m., R321 was sitting on her recliner chair and said she had not been invited to any recreational activities and had only left her room to work with the physical therapist. During interview on 6/24/25 at 2:22 p.m., nursing assistant (NA)-B stated the recreational aid invited and took residents to activities. NA-B stated the facility also had a pastor who made room visits and talked to residents. During interview on 6/25/25 at 9:15 a.m., R321 stated last afternoon and so far, today, she had not been invited to attend any activities. During interview on 6/25/25 at 10:06 a.m., NA-C stated the recreational aid went around every room and asked the residents if they wanted to play bingo on the second floor. R321's POC (Point of Care) History Report dated 6/2025, identified R321 had only one activity recorded as been completed since admitting to the care center on 6/6/25. This activity was recorded as a Pastor visit. During interview on 6/25/25 at 11:59 a.m., therapeutic activities director (TAD) stated his department met with all new residents to complete the Initial Activities Assessment. This assessment identified residents' hobbies and	F 679			

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F 679	Continued From page 18 interests, and the activities department offered resources like books, magazines, coloring books, word-finding books and others. TAD stated based on the Initial Activities Assessment, the residents were included on the activities list programs. TAD verified R321 had been added to the bingo, music, social activities, and religious services list programs. TAD verified R321's POC activities report only had one activity recorded since 6/6/25. TAD stated residents' participation in recreational activities were important for the overall well-being of the person, so they were able to do things that they liked to do. On 6/25/25 at 12:55 p.m., TAA and the surveyor reviewed the spiral top notebook identified previously. R321's room was located on these pages and identified a series of symbols (i.e., 'S' and 'O') which TAA explained in chronological order. This included: Week of 6/2/25 to 6/6/25 was reviewed. On 6/6/25 (R321's date of admission), the space had a written "V" on it. TAA stated this meant the room was vacant. Week of 6/9/25 to 6/13/25 was reviewed. On 6/9/25, the space had writing which read, "w/ aide." There were no other symbols written to show re-approach. On 6/10/25, the space had a checkmark drawn with text adjacent, "back around 3." There were no other symbols drawn to show re-approach happened. On 6/11/25, the space had a single checkmark drawn. TAA stated they were unsure what that meant. On 6/12/25 and 6/13/25, the spaces were left blank. Week of 6/16/25 to 6/20/25 was reviewed. On 6/16/25, the space had text written, "on phone."	F 679			

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F 679	Continued From page 19 There were no other symbols written to show reproach. On 6/17/25, a circle with a line drawn through it was written which TAA explained meant they didn't see R321 at all that day. On 6/18/25 and 6/19/25, both spaces to draw a symbol or record writing were left blank. On 6/20/25, a handwritten, "N/I," was placed which TAA stated meant R321 was not interested in the activity when offered. Week of 6/23/25 to 6/27/25 was reviewed. On 6/23/25, 6/24/25, and 6/25/25, each space had a written, "S," on its which TAA stated meant R321 was sleeping. The spaces each lacked any further symbols to show re-approach. A facility Therapeutic Activities policy, dated 11/2024, identified each facility within the corporation would provide ongoing programs to support residents in their choice of activities based on their assessment and care plan. The policy outlined, "Each resident will have an individualized activity plan of care addressing the four components of an activity program. There are large groups, small groups, one to one programs and self-directed activities." The policy outlined a schedule of activities would be posted one-week in advance, however, lacked information on how attempts or refusals of activities would be recorded or captured within the medical record.	F 679			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive	F 684			

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F 684	Continued From page 20 assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure non-pressure related wounds were monitored for signs and symptoms of infection and healing until resolved for 1 of 1 resident (R16) reviewed for skin concerns. Findings include: R16's significant change Minimal Data Set (MDS) dated 5/31/25, identified R16 had no cognitive impairment, diagnoses of arthritis, hypertension, dementia, depression, atrial fibrillation, was dependent on staff for all mobility, used a pressure reducing device for the bed and wheelchair, and was taking an anticoagulant (a medication that prevents blood clots). R16's MDS did not identify any current skin tears, abrasions or wounds. R16's skin integrity care plan (CP) dated 12/22/24, included interventions to reduce the risk for pressure ulcers including monitoring mobility, observing skin daily, and completing visual body audits weekly. R16 used a full body lift and needed two staff for transfers. R16's progress note dated 5/3/25, identified previous right shin skin tear that was covered with Tegaderm tape and had discharge, the dressing was removed, and the area was measured to be 4 cm x 4.5 cm. A request was sent to the wound	F 684			

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F 684	Continued From page 21 nurse to see R16 and staff were to continue to monitor. R16's active provider orders included an order to complete wound care for a right shin abrasion dated 5/8/25. The orders directed staff to change the dressing every other day as needed if soiled or if it fell off, cleanse with wound cleanser and gauze and pat dry, cover with a bordered gauze dressing, and initial/date the dressing. R16's wound management report documented the following: 5/3/25, observed skin tear that was 4 cm x 4.5 cm, red with pale red to pink, thin and watery fluid, scant wound tissue was moist and had a flap tear which could be repositioned to cover the wound bed. 5/15/25, observed skin tear that was 2.5 cm x 3 cm, red with pale red to pink, thin and watery fluid, a moderate amount of the wound tissues was wet and involved 25-75% of the dressing, total flap loss, entire wound bed was exposed. 5/22/25, observed skin tear that was 2 cm x 2 cm, bloody, bright red with a moderate amount of the wound tissues were wet and involved 25-75% of the dressing, total flap loss, entire wound bed was exposed. R16's medical record lacked documentation of further assessment, measurement, and/or resolved status of the skin tear between 5/22/25 and 6/23/25. R16's Comprehensive Skin Risk with Braden dated 5/30/25, identified a pressure injury was present, however a box titled skin tear/laceration present was unchecked, and no other ulcers, wounds, or skin problems were identified.	F 684			

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F 684	Continued From page 22 R16's Visual Body Inspections reported completed during weekly baths dated 6/2/25 through 6/23/25 lacked identification of any skin tears. R16's treatment assessment record (TAR) dated 5/27/25-6/25/25, identified wound care for right shin abrasion. Staff were to cleanse, pat dry, apply a cut to fit piece of calcium alginate to the wound bed, cover with a bordered foam dressing and initial/date. During observation and interview on 6/23/25 at 3:06 p.m., R16 stated his right shin bumped against the full body lift "a while back" and explained the wound took a while to heal. R16 indicated this happened on more than one occasion, but could not elaborate. R16 had a foam dressing dated '6/22' on the right shin with one additional visible small encrusted wound near the dressing the size of a dime, with no drainage or redness. During an interview on 6/24/25 at 11:28 a.m., family member (FM)-A stated the staff did the best they could and were careful with dressing changes, and explained when staff used the full body lifts with R16, R16's legs were bumped often. During an interview on 6/25/25 at 9:07 a.m., R16 stated his leg was "not really good" and wanted to know if there was someone he could talk to. The dressing on the right shin was still dated 6/22. During an observation and interview on 6/25/25 at 11:13 a.m., two nursing assistant (NA)-D and (NA)-F used a full body lift (Hoyer) to transfer R16	F 684			

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F 684	Continued From page 23 from the bed to the wheelchair. R16's right shin was observed to slide down against the battery on the pole of the lift. NA-D stated she never noticed his leg against the pole, was aware there was a bandage on the right shin, but was unaware of its origin or any interventions related to the lift, mobility, and skin monitoring, and referred questions to the nurse. During an interview on 6/25/25 at 12:09 a.m., nursing assistant (NA)-E stated she had been an aid for a long time and did not work directly with R16, but had assisted with transfers and stated his legs were stiff and needed to be loaded sideways onto the wheelchair preventing R16's legs from contacting the lift. During observation and interview on 6/25/25 at 11:20 a.m., registered nurse (RN)-D reviewed R16's medical record and was unable to determine the origin of R16's right shin skin tear, but did identify the active wound care order. RN-D confirmed the dressing changes were done on the evening shift and had not observed the wound today. RN-D then confirmed the bandage was initialed and dated 6/22. During an interview on 6/25/25 at 11:33 a.m., nurse manager (RN)-A stated an incident report would not be done for skin, the staff would care for the wound regardless or its origin, and the wound care nurse would not follow a skin abrasion/tear because it was not pressure related. RN-A stated normal practice would be to have a progress note accompany the wound assessment unless it was done on a body audit/bath day. RN-A was unaware R16 had a right shin skin tear and but then confirmed no progress note or audit was completed that	F 684			

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F 684	Continued From page 24 mentioned a skin tear around the date the wound care order was written. RN-A reviewed the "events tab" for April, May, and June then confirmed the record did not specify origin or date the wound occurred. During an interview on 6/25/25 at 12:39 p.m., the director of nursing (DON) stated new skin alterations would be on the wound management platform which started the monitoring process. It was expected to track and monitor all skin tears/abrasions regardless of their origin and a progress note or a note on the wound management platform should be documented. The policy was to monitor wounds every seven days document on the visual body audit, but the audit would only identify if it was a new skin wound. The DON expected that staff would be monitoring and assessing all skin wounds in the wound management platform. The DON identified no root cause analysis or interventions in place to prevent future injury to R16 and indicated this was an area the facility could improve, and stated the facility was currently without a wound nurse at this time. A policy, Skin integrity revised 3/10/25 identified Cassia facilities will use the wound management area of MatrixCare electronic health record to document skin integrity issues. Facilities with Point Click Care (PCC) will document wounds in the skin and wound area of PCC.	F 684			
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent	F 698			

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F 698	Continued From page 25 with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to effectively communicate with a dialysis center and failed to provide care consistent with professional standards of practice for 1 of 2 residents (R98) reviewed for dialysis. Findings include: R98's quarterly Minimum Data Set (MDS), dated 3/26/25, indicated R98 was admitted to the care facility on 7/10/24, was cognitively intact, and was receiving dialysis while a resident. R98 had a General Order, dated 7/11/24, indicating " Remove dressing from dialysis site on the shift after they return from dialysis (unless otherwise ordered)" and an order, dated 4/2/25, indicating R98 went to dialysis on Tuesdays, Thursdays and Saturdays. During observation and interview on 6/23/25 at 1:41 p.m., R98 was lying in bed without a shirt and the bedsheets pulled up over her chest. Exposed was a dialysis port, (a central venous catheter [CVC], which is a flexible, long, plastic, y-shaped tube that is threaded through the skin into a central vein in the neck.) The CVC was exposed to the air without covering. R98 stated she had received a bath earlier in the day and was waiting on the nurse to come and cover it. During follow up observation and interview on 6/25/25 at 8:40 a.m., R98 was lying in bed again,	F 698			

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F 698	Continued From page 26 with her dialysis port uncovered and exposed to open air. R98 stated the plastic covering placed by dialysis would often itch and she would remove it or ask staff to remove it when she came back from dialysis. During an interview on 6/25/25 at 9:30 a.m., nurse manager and registered nurse (RN)-A stated she believed the staff at the dialysis center were managing R98's dialysis port "for the most part". RN-A stated the port would remain covered for a short amount of time after R98's dialysis treatment and would be removed by care facility staff. RN-A stated communication between the facility and the dialysis center was done via a communication form uploaded under "Consults" in the electronic medical record (EMR). When reviewed with RN-A, the most recent communication form between the care center and the dialysis center was dated 4/17/25. RN-A further stated the facility did not always receive the communication forms back from the dialysis center. During an interview on 6/25/25 at 9:50 a.m., licensed practical nurse (LPN)-A stated when R98 returned from the dialysis center, the nurse at the care facility, on the next shift, would remove the clear plastic covering that kept the dialysis port from being exposed to open area and would clean R98's skin around the port with normal saline and leave it uncovered, open to air. During an interview on 6/25/25 at 10:22 a.m., the charge nurse at the dialysis center (CN) stated after R98 had a dialysis run, the staff at the dialysis center would clean the port and cover it with a clear plastic dressing to prevent infection. The CN stated staff at the care facility should not	F 698			

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F 698	Continued From page 27 be touching the dialysis port or dressing in between dialysis runs and that the clear plastic dressing should be left in place. The CN further stated the staff at the care facility had not been communicating with the dialysis center that they were removing the clear plastic film leaving R98 vulnerable for infection, or that the clear plastic film was itching R98, stating they had other dressings they could try had they known R98 was bothered by the clear plastic dressing. During an interview on 6/25/25 at 10:53 a.m., the director of nursing (DON) stated R98's order to remove the dressing from the dialysis site was a house standing order and was not intended for a resident who had a dialysis port, but rather a fistula (a surgical connection made between an artery and a vein) which does not require a cover for infection control. The DON confirmed the dressing covering R98's dialysis port should not be removed, which put R98 at a higher risk for infection, and there was concern about collaboration with the dialysis center. A facility policy titled Dialysis, reviewed 3/10/2025, indicated "residents who require dialysis will receive this service consistent with professional standards of practice and the comprehensive person-centered plan of care" and the facility would have "ongoing communication and collaboration with the dialysis facility."			F 698			

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs		PROVIDER # 245264	MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	DATE SURVEY COMPLETE: 6/24/2025
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES			
K 353	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. This deficient finding could an isolated impact on the residents within the facility. Findings include: On 06/24/2025, at 8:40 AM, it was revealed by observation that storage materials had been placed within 18" of the sprinkler system within the Kitchen Freezer. On 06/24/2025, at 8:40 AM, it was revealed by observation that wires were resting on the sprinkler system in the hallway on the Lower Level and also in the Lower Level Storage Room. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			
	K 901	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99)		

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

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs		PROVIDER # 245264	MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	DATE SURVEY COMPLETE: 6/24/2025
NAME OF PROVIDER OR SUPPLIER APPLE VALLEY VILLAGE HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES			
K 901	Continued From Page 1 This REQUIREMENT is not met as evidenced by: Based on observation and document review, the facility did not implement a risk assessment procedure for building systems designed to meet Category 1 through 4 in accordance with NFPA 99, Chapter 4. This deficient finding could have an isolated impact on the residents within the facility Findings include: On 06/24/2025, at 8:46 AM, it was revealed that at the time of the survey, the facility was unable to provide documentation of the Facility Risk Assessment required under NFPA 99 Chapter 4. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245264		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/25/2025	
NAME OF PROVIDER OR SUPPLIER APPLE VALLEY VILLAGE HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE , APPLE VALLEY, Minnesota, 55124			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
E0000	Initial Comments On 6/23/25 to 6/25/25, a survey for compliance with CMS Appendix Z, Emergency Preparedness Requirements, was conducted during a standard recertification survey. The facility was found in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.		E0000			08/04/2025	
F0000	INITIAL COMMENTS On 6/23/25 through 6/25/25, a standard recertification survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint were reviewed with no deficiencies cited: H52647537 MN00108959 H52647618 MN00108564 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 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.		F0000			08/04/2025	
F0605 SS = D	Right to be Free from Chemical Restraints		F0605	Plan of Correction:		08/04/2025	

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245264		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/25/2025		
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F0605 SS = D	Continued from page 1 CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant;			F0605	Continued from page 1 F605 It is the policy of Cassia Apple Valley Village Health Care Center to comply with 42 CFR §483.45(d) Unnecessary Drugs, specifically ensuring that residents receiving antipsychotic medications are monitored for side effects, including orthostatic hypotension. To assure continued compliance, the following plan has been put into place: The following corrective action will be done for the resident(s) found to have been affected by the deficient practice: • Resident R79 was immediately assessed for orthostatic hypotension and monitoring was initiated. The resident's primary care team were notified of the findings. Actions taken to identify other potential residents having similar occurrences: • A review was conducted of all residents currently receiving antipsychotic medications to determine if appropriate side effect monitoring, including for orthostatic hypotension, was being completed. Measures put in place to ensure deficient practice does not recur: • All licensed nursing staff were re-educated on the importance of monitoring for orthostatic hypotension in residents receiving antipsychotic medications. Facility collaborated with home office staff to review and revise Cassia-wide order set for orthostatic blood pressure to ensure clarity for licensed staff completing order and completeness of documentation. Effective implementation of actions will be monitored by: The Director of Nursing or designee will audit 100% of residents receiving antipsychotic medications weekly for three months to ensure orthostatic hypotension monitoring is completed and documented. Results of these audits will be reviewed by the facility QAPI			

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F0605 SS = D	Continued from page 2 (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the			F0605	Continued from page 2 committee and they will make the decision if further monitoring/audits are recommended. The person responsible to maintain compliance is: Director of Nursing Completion date: August 4th, 2025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245264		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/25/2025	
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F0605 SS = D	Continued from page 3 resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure appropriate side effect monitoring for potential orthostatic hypotension (sudden drop in blood pressure what occurs when a person stands up after sitting or lying down) was completed for 1 of 5 residents (R79) reviewed for unnecessary medication use and who consumed antipsychotic medication. Findings include: A National Library of Medicine (NIH) Management of Commons Adverse Effects of Antipsychotic Medication article, dated 9/2018, identified the elderly were at risk of adverse effects (i.e., falls) of antipsychotic medication. The article outlined, "All antipsychotics carry some risk of orthostatic hypotension ... [which can] lead to dizziness, syncope, falls ... it should be evaluated by both history and measurement ... Risk factors include systemic diseases causing autonomic instability (e.g., diabetes, alcohol dependence, Parkinson's disease), dehydration, drug-drug interactions, and age." R79's quarterly Minimum Data Set (MDS), dated 5/6/25, identified R79 had moderate cognitive impairment and demonstrated no hallucinations or delusional thinking during the review period. Further, the MDS recorded R79 consumed both antipsychotic and antidepressant medication(s). R79's View General Order, printed 6/25/25, identified a current nursing order which read, "Complete orthostatic blood pressure and pulse d/t use of antipsychotic medication," with a frequency listed, "Once a day on the 20th of Every 3rd Month." The order continued and listed instructions which read, "Enter lying, sitting, and standing BPs and Pulse under vital signs separately AND put in progress note," The order had a start date			F0605			

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F0605 SS = D	Continued from page 4 recorded, "11/20/2024." R79's Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 2/2025, identified R79's recorded medication administrations and treatments for the period. The MAR listed the nursing order to complete the orthostatic blood pressure and pulse, along with spacing to record data for these collected vital signs with a date of 2/20/25. However, only a single blood pressure was listed which read, "141/67," and the MAR lacked what position R79 was in when it was obtained (i.e., lying, sitting, standing). R79's corresponding Search Vital Results, dated 1/2025 to 6/2025, only recorded the same reading of, "141/67," on 2/20/25 and also lacked information on which position R79 was in when the reading was obtained. R79's MAR and TAR, dated 5/2025, identified the same nursing order and spaces to record data for the collected vital signs with a date of 5/20/25. However, again, only a single blood pressure was listed which read, "125/60," and the MAR lacked what position R79 was in when it was obtained (i.e., lying, sitting, standing). R79's corresponding Search Vital Results, dated 1/2025 to 6/2025, only recorded the same reading of, "125/60," on 5/20/25 and also lacked information on which position R79 was in when the reading was obtained. On 6/24/25 at 1:52 p.m., registered nurse (RN)-C was interviewed, and verified they had worked with R79 prior. RN-C explained R79 was not ambulatory, however, he did transfer using a stand-by assist and did bear weight for them. RN-C stated R79 had some troubles with communication and often times wouldn't converse with staff adding, "He doesn't talk." RN-C stated R79 had not complained about dizziness or lightheadedness with transfers to their knowledge. RN-C explained orthostatic blood pressures were done only if ordered on the MAR or TAR, and expressed R79 did not have an order for them to their knowledge. RN-C reviewed R79's MAR in the medical record (June 2025) and stated it lacked direction to complete orthostatic blood pressures adding, "We don't have an order for that." RN-C stated they obtained R79's blood pressure earlier that day, on 6/24/25, and it had been 146/66 which RN-C stated "a little high" for him. R79's medical record, including progress notes, was		F0605				

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F0605 SS = D	Continued from page 5 reviewed and lacked evidence R79 had a complete set of orthostatic blood pressures obtained or checked within the past several months, nor was there documented rationale for the lack of a complete set of them, despite R79 consuming antipsychotic medications. On 6/24/25 at 3:10 p.m., registered nurse unit manager (RN)-B was interviewed, and verified they had reviewed R79's medical record. RN-B stated R79 consumed Risperdal (antipsychotic) and they were unable to locate any complete sets of orthostatic blood pressures documented in the record for the past several cycles when due (i.e., Feb 25, May 25) adding aloud, "I did not [find any]." RN-B stated the floor nurses should be obtaining the orthostatic blood pressures and entering them into the medical record per the nursing order. RN-B reviewed R79's medical record and verified R79 transferred with a stand-by assist and expressed, "He does bear weight [with them]." RN-B stated staff should document rationale for why, if applicable, they were unable to complete the orthostatic blood pressures; however, again this was not found, either. RN-B stated R79 had sustained a few falls within the past several months, including during episode of self-transfers, and it was important to obtain orthostatic blood pressures as it was "in our policy" to do so and for "the best interest of the patient." When interviewed on 6/25/25 at 10:51 a.m., the director of nursing (DON) stated a complete set of orthostatic blood pressures should be obtained every 90 days and recorded in the medical record. DON stated they completed a house-wide audit of this process the day prior when the issue arose during survey and were working on potentially adjusting their "order set" to better capture the data. DON acknowledged R79 had several falls within the past few months and expressed R79 seemed to "ebb and flow" with mobility adding, at times, he would be more mobile and anxious. DON verified they reviewed R79's medical record, including fall reports, and were unable to locate any orthostatic blood pressures being done or attempted since November 2024. DON reiterated they should be completed every 90 days in accordance with their policy on antipsychotic medication use which was developed in collaboration with their corporate pharmacy. This was important to do as the medication "can have a major effect on their blood pressure" and increase the risk of falls. A facility provided Psychotropic Medication Monitoring policy, dated 4/2025, identified a section labeled,		F0605				

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F0605 SS = D	Continued from page 6 "Antipsychotic," and directed, "1. Orthostatic blood pressures are checked monthly X 3 with new antipsychotic orders ... then quarterly for residents on antipsychotic medications if the resident is physically able to participate in Orthostatic [sic] BP measurements."	F0605		
F0679 SS = D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is NOT MET as evidenced by: R321 R321's admission Minimum Data Set (MDS), dated 6/11/25, indicated R321 was cognitively intact, had no delusions or hallucinations, had no behaviors and did not refused cares. The MDS recorded under section F Preferences for Customary Routines and Activities, R321 felt it was "Very important" to do her favorite activities, participate in religious practices, and keep up with the news; and she felt it was "Somewhat important" to have books, magazines to read, to do things with group of people, and to go outside to get fresh air when the weather was good. R321 Therapeutic Activities Observation dated 6/8/25, identified the evaluation as, "Initial Activities Assessment," and recorded R321 as having an anticipated length of stay as, "Less than 3 months." The assessment indicated R321 had current interest in pursuing leisure/activities and indicated R321 was interested in bingo, music entertainment, social events and attending Catholic services. The evaluation continued, R321's independent leisure interests included watching TV, going outside with family when weather was good, family visits, using her personal iPhone for streaming, games, internet searches and social media. Doing group activities, doing favorite activities, getting outdoors	F0679	Plan of Correction F679 It is the policy of Cassia Apple Valley Village Health Care Center to comply with F679: Activities Meet Interests/Needs Each Resident. To assure continued compliance, the following plan has been put into place; The following corrective action will be done for the resident(s) found to have been affected by the deficient practice: Activities of interest were immediately offered and provided to residents R58 and R321. Documentation of activities provided was completed in their medical records. Actions taken to identify other potential residents having similar occurrences: All residents residing on the transitional care unit were reviewed to determine if activities of interest were consistently offered, provided, and documented. Measures put in place to ensure deficient practice does not recur Activity Attendance policy was revised to ensure the activity needs of transitional care residents are assessed on a weekly basis and as needed. Activity staff educated on changes to the policy. Effective implementation of actions will be monitored by: The Activity Director or designee will audit 10% of	08/04/2025

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F0679 SS = D	Continued from page 7 and participating in religious services/practices were categorized as very important or somewhat important. R321's Activities Care Plan dated 6/8/25, titled Outdoor Activity included: "Going outdoors is important for patient" indicated, R321 will remain safe when going outdoors evidenced by no accidents or injuries in the process. Care plan also indicated R321 was instructed to inform staff when going outdoors and was warned about sloped front parking lot, and that she may safely go outside with family assistance and supervision. In addition, care plan indicated if R321 attempted or requested to go outside alone, further safety screening may be needed. During interview on 6/23/25 at 3:15 p.m., R321 was sitting on a recliner and said she had been at the facility since 6/6/25. R321 stated she was not aware if the facility had any activities, and added "Nobody has mentioned anything about activities" and had not been invited to go to an activity. R321 further stated, "I do not have an activity schedule in my room." During interview on 6/24/25 at 12:53 p.m., R321 was sitting on her recliner chair and said she had not been invited to any recreational activities and had only left her room to work with the physical therapist. During interview on 6/24/25 at 2:22 p.m., nursing assistant (NA)-B stated the recreational aid invited and took residents to activities. NA-B stated the facility also had a pastor who made room visits and talked to residents. During interview on 6/25/25 at 9:15 a.m., R321 stated last afternoon and so far, today, she had not been invited to attend any activities. During interview on 6/25/25 at 10:06 a.m., NA-C stated the recreational aid went around every room and asked the residents if they wanted to play bingo on the second floor. R321's POC (Point of Care) History Report dated 6/2025, identified R321 had only one activity recorded as been completed since admitting to the care center on 6/6/25. This activity was recorded as a Pastor visit.			F0679	Continued from page 7 resident charts on the transitional care unit weekly for three months to ensure activities of interest are offered, provided, and documented. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended. The person responsible to maintain compliance is: Activities Director Completion date: August 4th, 2025		

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F0679 SS = D	Continued from page 8 During interview on 6/25/25 at 11:59 a.m., therapeutic activities director (TAD) stated his department met with all new residents to complete the Initial Activities Assessment. This assessment identified residents' hobbies and interests, and the activities department offered resources like books, magazines, coloring books, word-finding books and others. TAD stated based on the Initial Activities Assessment, the residents were included on the activities list programs. TAD verified R321 had been added to the bingo, music, social activities, and religious services list programs. TAD verified R321's POC activities report only had one activity recorded since 6/6/25. TAD stated residents' participation in recreational activities were important for the overall well-being of the person, so they were able to do things that they liked to do. On 6/25/25 at 12:55 p.m., TAA and the surveyor reviewed the spiral top notebook identified previously. R321's room was located on these pages and identified a series of symbols (i.e., 'S' and 'O') which TAA explained in chronological order. This included: Week of 6/2/25 to 6/6/25 was reviewed. On 6/6/25 (R321's date of admission), the space had a written "V" on it. TAA stated this meant the room was vacant. Week of 6/9/25 to 6/13/25 was reviewed. On 6/9/25, the space had writing which read, "w/ aide." There were no other symbols written to show re-approach. On 6/10/25, the space had a checkmark drawn with text adjacent, "back around 3." There were no other symbols drawn to show re-approach happened. On 6/11/25, the space had a single checkmark drawn. TAA stated they were unsure what that meant. On 6/12/25 and 6/13/25, the spaces were left blank. Week of 6/16/25 to 6/20/25 was reviewed. On 6/16/25, the space had text written, "on phone." There were no other symbols written to show reproach. On 6/17/25, a circle with a line drawn through it was written which TAA explained meant they didn't see R321 at all that day. On 6/18/25 and 6/19/25, both spaces to draw a symbol or record writing were left blank. On 6/20/25, a handwritten, "N/I," was placed which TAA stated meant R321 was not interested in the activity when offered.		F0679				

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F0679 SS = D	Continued from page 9 Week of 6/23/25 to 6/27/25 was reviewed. On 6/23/25, 6/24/25, and 6/25/25, each space had a written, "S," on its which TAA stated meant R321 was sleeping. The spaces each lacked any further symbols to show re-approach. A facility Therapeutic Activities policy, dated 11/2024, identified each facility within the corporation would provide ongoing programs to support residents in their choice of activities based on their assessment and care plan. The policy outlined, "Each resident will have an individualized activity plan of care addressing the four components of an activity program. There are large groups, small groups, one to one programs and self-directed activities." The policy outlined a schedule of activities would be posted one-week in advance, however, lacked information on how attempts or refusals of activities would be recorded or captured within the medical record. Based on observation, interview, and document review, the facility failed to ensure activities of interest were consistently offered, provided and documented within the medical record to support ongoing engagement and continuity of care for 2 of 2 residents (R58, R321) reviewed for activities and who resided on the transitional care unit (i.e., TCU). Findings include: R58 R58's admission Minimum Data Set (MDS, dated 6/7/25, identified R58 admitted to the care center on 6/2/25, and she had moderate cognitive impairment but demonstrated no delusional thinking during the review period. The MDS recorded under Section F - Preferences for Customary Routine and Activities that R58 felt it was "Very important" to do her favorite activities and keep up with the news; and she felt it was "Somewhat important" to have books, newspapers, or magazines and do things with group(s) of people. On 6/23/25 at 1:59 p.m., R58 was observed lying in bed while in her room. R58's eyes opened with audible interaction, and R58 stated she had been at the care center for "just about 24 hours" she thought. R58 had			F0679			

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F0679 SS = D	Continued from page 10 one visible, red-colored Word Search on her bedside dresser which was placed underneath various items such as other papers and a package of disposable wipes. R58's lacked any visible activities calendar on the wall. R58 stated she was not sure what, if any, activities she had been attending and expressed she "mostly rests" she thought. R58 stated she didn't recall anybody offering to take her to activities but added she'd like to go to them, if offered, adding aloud, "Oh, of course!" R58 stated she enjoyed many activities prior to coming to the care center such as going for walks, light exercises, and reading and doing puzzles. R58's Therapeutic Activities Observation, dated 6/3/25, identified the evaluation as, "Initial Activities Assessment," and recorded R58 as having an anticipated length of stay as, "Less than 3 months." The evaluation recorded R58's demographic information (i.e., statistical data) and identified R58 as being Lutheran and attending services prior to admission. R58's preferred activities' program style was recorded as, "Large Groups," and "Independent leisure." The option reading, "One to One [1:1]," was left unchecked. A section labeled, "Describe resident's past interests," outlined R58 enjoyed participating in her senior community, playing board games, visits with family and watching television. The evaluation continued, "[R58] is interested in music entertainment, social events and attending worship services. Independent leisure interests include watching TV, reading books she has brought with her, and TP [therapeutic programming] library books, going outside with family when weather is good and family visits." The evaluation directed, "Initiate care plan." R58's corresponding Therapeutic Activities progress note, dated 6/3/25, identified staff met with R58 and welcomed her to the TCU. R58 was provided a community newsletter and "... TP Things To Do flyer." The staff recorded they answered questions about activities and outlined, "[R58] is here for short term rehab and has interests in group and independent pursuits during his/her stay ... is interested in music entertainment, social events and attending worship services ... leisure interests include watching TV, reading books she has brought with her and TP library books ... " R58's activities care plan, initiated 6/22/25, identified R58 was at the care center for short-term rehab and, again, outlined her interests in group and			F0679			

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F0679 SS = D	Continued from page 11 independent leisure activities. The plan listed a goal which read, "Resident will participate in activities of choice," along with three interventions including, "Invite and remind of programs," and "Offer activity schedule." When interviewed on 6/24/25 at 1:31 p.m., nursing assistant (NA)-A stated they had worked with R58 prior and explained R58 needed help with transfers and most cares. NA-A was asked what, if any, group activities R58 attends and NA-A responded, "Therapy [PT/OT]." NA-A stated they had not observed R58 to attend any group activities or events while on the TCU and reiterated aloud, "PT/OT." NA-A stated the TCU did have a dedicated activities staff member; however, they were unsure of their name. NA-A stated R58 had never verbally complained about being bored to them, however, when asked how R58 seemed to spend their day when not with therapy NA-A responded aloud, "mostly nap and then watch the TV." R58's POC (Point of Care) History Report (3 Records), dated 6/2025 and provided by the therapeutic activities director (TAD), identified R58 had only three (3) activities recorded as being completed since admitting to the care center on 6/2/25 (over 20 days prior). These were recorded as three separate 1:1's completed on 6/4/25, 6/12/25, and 6/16/25 with their length being 15 minutes, 40 minutes, and 10 minutes, respectively. The provided report lacked any evidence of what, if any, group-based activities (i.e., music, worship services) had been offered or attended by R58 despite these being identified as activities she was interested in. Further, R58's entire electronic medical record (EMR) was reviewed and lacked evidence R58 had been consistently invited, offered or attended any additional activities (including in-room activities like puzzles) outside of the three recorded 1:1 sessions since admitting to the care center. On 6/25/25 at 9:42 a.m., the TAD was interviewed and R58's POC History Report reviewed. TAD explained there were two people who assisted with activities on the TCU, and they visited residents upon admission to do an initial interview about their interests which is then recorded on an internal "checklist." The staff then review that checklist and compare it to which residents expressed interest in which type of activities to help determine who is invited to them. TAD reviewed R58's medical record and verified it outlined R58 expressed interest in music entertainment, social events, and		F0679				

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F0679 SS = D	Continued from page 12 attending worship services. However, TAD expressed only physically attended activities were recorded in the medical record (i.e., POC History Report) and there was no system to record offered and/or declined activities adding aloud, "Those are things that are not documented." TAD verified R58's medical record only have three 1:1 recorded since she admitted to the care center, and expressed a majority of residents on TCU were more therapy-focused instead of activities-focused. TAD stated they had visited with their assistants on the TCU who expressed they had "stopped and talked to her [R58] multiple times" but, again, acknowledged these visits were not documented within the medical record. TAD stated R58 having three recorded 1:1 completed "seems good," and expressed if someone, including R58 or staff who work with her, had expressed concerns about R58 need "greater engagement" then they would have re-visited it with R58; however, nobody had ever reported concerns to the activities department to their knowledge. TAD explained each resident on the TCU was given a "community news" letter which had an included activities calendar. TAD reviewed the June 2025 calendar and verified it had multiple, scheduled music programs and social events listed on it since R58 admitted, however, again, TAD acknowledged none of these were recorded in the record as being offered or attended. TAD explained documenting offers to attend and refusals for activities were something that had "gone back and forth" with the corporate level but "their philosophy" was to solely document the ones attended adding, "The emphasis has not been on the refusals, [but] has been on the actual engagements." TAD stated the only 'proof' to show R58 was being offered activities was based on "word of mouth," and again expressed, "I don't have anything in writing." TAD acknowledged activities were important and expressed making sure residents were invited and attending them was important as "it's our mission to meet their needs." TAD added, "[Activities] helps their fullness of life." TAD then expressed they amended their process "recently" to do a routine 30-day follow-up note (i.e., progress note) on TCU residents where they review attendance and engagement; and from this they could re-vise their care plan to ensure more activities involvement. TAD and the surveyor then reviewed a sample of other residents who had resided on the TCU since admission and had been present for over 30 days. A total of four (4) residents were reviewed and all of these lacked any completed 30-day note(s) in their record. TAD stated, "We may have missed some of them," adding further, "There's something going on with that process that doesn't seem to be happening."			F0679			

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F0679 SS = D	Continued from page 13 Later, on 6/25/25 at 12:43 p.m., TAD e-mailed the surveyor with a note, "I checked with my activity assistant and found she has some additional document about inviting residents to programs. It is not part of the medical record, but she keeps a notebook. Would you be interested in seeing it?" On 6/25/25 at 12:55 p.m., TAD and the activities assistant (TAA) were interviewed, and TAA explained they started keeping a notebook on their own accord as they had repeatedly had issues "hooking up" with residents for activities. TAA and the surveyor reviewed this notebook, which was a small, spiral top notebook that had columns written on the pages with included room number(s) along with days of the week outlined across the top. R58's room was located on these pages and identified a series of symbols (i.e., 'S' and 'O') which TAA explained in chronological order. This included: Week of 6/2/25 to 6/6/25 was reviewed. On 6/3/25 and 6/4/25, a handwritten, "N/I," was written which TAA stated meant R58 was not interested in activities. On 6/5/25, nothing was recorded, and the space was left blank. On 6/6/25, a handwritten, "w/ aide [NA]," was written. However, this notebook did not include documentation or symbols to show the 1:1 which had been recorded in the POC History on 6/4/25; nor did the notebook outline if R58 was reproached about activities on 6/6/25. Week of 6/9/25 to 6/13/25 was reviewed. On 6/9/25 and 6/10/25, these dates each had a one symbol which looked like a circle with a line drawn through them. TAA explained these symbols meant they "didn't see them at all" that day, and verified they only checked once each day based on the symbols drawn. On 6/11/25, a symbol was recorded which was shaped like a checkmark; however, TAA could not recall what this meant. On 6/12/25, a handwritten, "Sleepin," was recorded and TAA verified they didn't check on R58 again based on the symbols drawn. In addition, again, this notebook did not include documentation or symbols to show the 1:1 which had been recorded in the POC History on 6/12/25. Week of 6/16/25 to 6/20/25 was reviewed. On 6/16/25, the space had four symbols of the circle with a line drawn through them on which, again, TAA explained meant they didn't see R58 on that day. Then, below those symbols, was handwritten text reading, "Very Confused 10 mon [sic; 1:1 per POC] visit Very Confused." On 6/17/25, the space had, "N/I," written along with two circles with a line through it and text reading,		F0679				

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F0679 SS = D	Continued from page 14 "Confused [and] Crabby." On 6/18/25, a circle with a line through it was drawn and, again, text reading, "Still Very Confused." On 6/19/25, one circle with a line drawn through it was present; and on 6/20/25 there was handwritten text reading, "Sleeping." The notebook lacked evidence R58 was reproached about activities on 6/19/25 or 6/20/25 based on the symbols drawn. Week of 6/23/25 to 6/27/25 was reviewed. On 6/23/25, the space had another checkmark drawn along with writing, "[name] @ 2:00." On 6/24/25 and 6/25/25, the spaces were blank with nothing written or drawn. TAA verified the notebook didn't record any weekend activities, and stated such was because they didn't work weekends. TAA reiterated the notebook was made by themselves and had not been directed to be used. Further, TAA stated they rarely, if ever, woke people up for activities if they were found to be asleep at that time and expressed nobody from the care center (i.e., TAD or management) had ever told them to chart these attempts or refusals (i.e., N/I) in the medical record before. In total, between the POC History Report and the presented notebook, a total of only seven (7) times were recorded to prove R58 was provided an activity (i.e., 1:1) or directly offered an activity since her admission to the care center on 6/2/25 (23 days prior); and only three of these were recorded within the actual medical record.		F0679				
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure non-pressure related wounds were monitored for signs and symptoms of		F0684	Plan of Correction: F684 It is the policy of Cassia Apple Valley Village Health Care Center to comply with 42 CFR §483.25(c) – Quality of Care, specifically ensuring that residents with non-pressure related wounds receive appropriate care and services to promote healing, prevent infection, and prevent new wounds from developing. To assure continued compliance, the following plan has been put into place: The following corrective action will be done for the resident(s) found to have been affected by the deficient practice:		08/04/2025	

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F0684 SS = D	Continued from page 15 infection and healing until resolved for 1 of 1 resident (R16) reviewed for skin concerns. Findings include: R16's significant change Minimal Data Set (MDS) dated 5/31/25, identified R16 had no cognitive impairment, diagnoses of arthritis, hypertension, dementia, depression, atrial fibrillation, was dependent on staff for all mobility, used a pressure reducing device for the bed and wheelchair, and was taking an anticoagulant (a medication that prevents blood clots). R16's MDS did not identify any current skin tears, abrasions or wounds. R16's skin integrity care plan (CP) dated 12/22/24, included interventions to reduce the risk for pressure ulcers including monitoring mobility, observing skin daily, and completing visual body audits weekly. R16 used a full body lift and needed two staff for transfers. R16's progress note dated 5/3/25, identified previous right shin skin tear that was covered with Tegaderm tape and had discharge, the dressing was removed, and the area was measured to be 4 cm x 4.5 cm. A request was sent to the wound nurse to see R16 and staff were to continue to monitor. R16's active provider orders included an order to complete wound care for a right shin abrasion dated 5/8/25. The orders directed staff to change the dressing every other day as needed if soiled or if it fell off, cleanse with wound cleanser and gauze and pat dry, cover with a bordered gauze dressing, and initial/date the dressing. R16's wound management report documented the following: 5/3/25, observed skin tear that was 4 cm x 4.5 cm, red with pale red to pink, thin and watery fluid, scant wound tissue was moist and had a flap tear which could be repositioned to cover the wound bed. 5/15/25, observed skin tear that was 2.5 cm x 3 cm, red with pale red to pink, thin and watery fluid, a		F0684	Continued from page 15 Resident R16's non-pressure related wound was immediately assessed by the licensed nurse, and wound care was provided per physician orders. The wound was monitored for signs and symptoms of infection and healing, and documentation was updated to reflect ongoing assessment until resolution. Actions taken to identify other potential residents having similar occurrences: All current residents were reviewed to identify any with non-pressure related wounds. Identified residents had their wounds assessed on next scheduled day of bathing for signs and symptoms of infection and healing, and documentation was reviewed and updated as needed. Measures put in place to ensure deficient practice does not recur: Licensed nursing staff were re-educated on the importance of monitoring and documenting non-pressure related wounds for infection and healing until resolved. Effective implementation of actions will be monitored by: The Director of Nursing or designee will audit 100% of resident charts with non-pressure related wounds weekly for three months to ensure wounds are monitored for signs and symptoms of infection and healing until resolved. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended. The person responsible to maintain compliance is: Director of Nursing Completion date: August 4th, 2025			

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F0684 SS = D	Continued from page 16 moderate amount of the wound tissues was wet and involved 25-75% of the dressing, total flap loss, entire wound bed was exposed. 5/22/25, observed skin tear that was 2 cm x 2 cm, bloody, bright red with a moderate amount of the wound tissues were wet and involved 25-75% of the dressing, total flap loss, entire wound bed was exposed. R16's medical record lacked documentation of further assessment, measurement, and/or resolved status of the skin tear between 5/22/25 and 6/23/25. R16's Comprehensive Skin Risk with Braden dated 5/30/25, identified a pressure injury was present, however a box titled skin tear/laceration present was unchecked, and no other ulcers, wounds, or skin problems were identified. R16's Visual Body Inspections reported completed during weekly baths dated 6/2/25 through 6/23/25 lacked identification of any skin tears. R16's treatment assessment record (TAR) dated 5/27/25-6/25/25, identified wound care for right shin abrasion. Staff were to cleanse, pat dry, apply a cut to fit piece of calcium alginate to the wound bed, cover with a bordered foam dressing and initial/date. During observation and interview on 6/23/25 at 3:06 p.m., R16 stated his right shin bumped against the full body lift "a while back" and explained the wound took a while to heal. R16 indicated this happened on more than one occasion, but could not elaborate. R16 had a foam dressing dated '6/22' on the right shin with one additional visible small encrusted wound near the dressing the size of a dime, with no drainage or redness. During an interview on 6/24/25 at 11:28 a.m., family member (FM)-A stated the staff did the best they could and were careful with dressing changes, and explained when staff used the full body lifts with R16, R16's legs were bumped often. During an interview on 6/25/25 at 9:07 a.m., R16 stated			F0684			

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F0684 SS = D	Continued from page 17 his leg was "not really good" and wanted to know if there was someone he could talk to. The dressing on the right shin was still dated 6/22. During an observation and interview on 6/25/25 at 11:13 a.m., two nursing assistant (NA)-D and (NA)-F used a full body lift (Hoyer) to transfer R16 from the bed to the wheelchair. R16's right shin was observed to slide down against the battery on the pole of the lift. NA-D stated she never noticed his leg against the pole, was aware there was a bandage on the right shin, but was unaware of its origin or any interventions related to the lift, mobility, and skin monitoring, and referred questions to the nurse. During an interview on 6/25/25 at 12:09 a.m., nursing assistant (NA)-E stated she had been an aid for a long time and did not work directly with R16, but had assisted with transfers and stated his legs were stiff and needed to be loaded sideways onto the wheelchair preventing R16's legs from contacting the lift. During observation and interview on 6/25/25 at 11:20 a.m., registered nurse (RN)-D reviewed R16's medical record and was unable to determine the origin of R16's right shin skin tear, but did identify the active wound care order. RN-D confirmed the dressing changes were done on the evening shift and had not observed the wound today. RN-D then confirmed the bandage was initialed and dated 6/22. During an interview on 6/25/25 at 11:33 a.m., nurse manager (RN)-A stated an incident report would not be done for skin, the staff would care for the wound regardless of its origin, and the wound care nurse would not follow a skin abrasion/tear because it was not pressure related. RN-A stated normal practice would be to have a progress note accompany the wound assessment unless it was done on a body audit/bath day. RN-A was unaware R16 had a right shin skin tear and but then confirmed no progress note or audit was completed that mentioned a skin tear around the date the wound care order was written. RN-A reviewed the "events tab" for April, May, and June then confirmed the record did not specify origin or date the wound occurred. During an interview on 6/25/25 at 12:39 p.m., the director of nursing (DON) stated new skin alterations would be on the wound management platform which started			F0684			

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F0684 SS = D	Continued from page 18 the monitoring process. It was expected to track and monitor all skin tears/abrasions regardless of their origin and a progress note or a note on the wound management platform should be documented. The policy was to monitor wounds every seven days document on the visual body audit, but the audit would only identify if it was a new skin wound. The DON expected that staff would be monitoring and assessing all skin wounds in the wound management platform. The DON identified no root cause analysis or interventions in place to prevent future injury to R16 and indicated this was an area the facility could improve, and stated the facility was currently without a wound nurse at this time. A policy, Skin integrity revised 3/10/25 identified Cassia facilities will use the wound management area of MatrixCare electronic health record to document skin integrity issues. Facilities with Point Click Care (PCC) will document wounds in the skin and wound area of PCC.	F0684		
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to effectively communicate with a dialysis center and failed to provide care consistent with professional standards of practice for 1 of 2 residents (R98) reviewed for dialysis. Findings include: R98's quarterly Minimum Data Set (MDS), dated 3/26/25, indicated R98 was admitted to the care facility on 7/10/24, was cognitively intact, and was receiving dialysis while a resident. R98 had a General Order, dated 7/11/24, indicating "	F0698	Plan of Correction: F698 It is the policy of Cassia to comply with 42 CFR §483.25(l) – Dialysis, ensuring residents receive care and services consistent with professional standards of practice and effective communication with dialysis centers. To assure continued compliance, the following plan has been put into place: The following corrective action will be done for the resident(s) found to have been affected by the deficient practice: Resident R98's care plan was immediately reviewed and updated to reflect current dialysis needs. Communication with the dialysis center was established to ensure all relevant information was shared and coordinated care was provided. Actions taken to identify other potential residents having similar occurrences: All current residents receiving dialysis were reviewed to ensure effective communication with their dialysis	08/04/2025

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NAME OF PROVIDER OR SUPPLIER APPLE VALLEY VILLAGE HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE , APPLE VALLEY, Minnesota, 55124			
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F0698 SS = D	Continued from page 19 Remove dressing from dialysis site on the shift after they return from dialysis (unless otherwise ordered)" and an order, dated 4/2/25, indicating R98 went to dialysis on Tuesdays, Thursdays and Saturdays. During observation and interview on 6/23/25 at 1:41 p.m., R98 was lying in bed without a shirt and the bedsheets pulled up over her chest. Exposed was a dialysis port, (a central venous catheter [CVC], which is a flexible, long, plastic, y-shaped tube that is threaded through the skin into a central vein in the neck.) The CVC was exposed to the air without covering. R98 stated she had received a bath earlier in the day and was waiting on the nurse to come and cover it. During follow up observation and interview on 6/25/25 at 8:40 a.m., R98 was lying in bed again, with her dialysis port uncovered and exposed to open air. R98 stated the plastic covering placed by dialysis would often itch and she would remove it or ask staff to remove it when she came back from dialysis. During an interview on 6/25/25 at 9:30 a.m., nurse manager and registered nurse (RN)-A stated she believed the staff at the dialysis center were managing R98's dialysis port "for the most part". RN-A stated the port would remain covered for a short amount of time after R98's dialysis treatment and would be removed by care facility staff. RN-A stated communication between the facility and the dialysis center was done via a communication form uploaded under "Consults" in the electronic medical record (EMR). When reviewed with RN-A, the most recent communication form between the care center and the dialysis center was dated 4/17/25. RN-A further stated the facility did not always receive the communication forms back from the dialysis center. During an interview on 6/25/25 at 9:50 a.m., licensed practical nurse (LPN)-A stated when R98 returned from the dialysis center, the nurse at the care facility, on the next shift, would remove the clear plastic covering that kept the dialysis port from being exposed to open area and would clean R98's skin around the port with normal saline and leave it uncovered, open to air. During an interview on 6/25/25 at 10:22 a.m., the charge nurse at the dialysis center (CN) stated after R98 had a dialysis run, the staff at the dialysis center would clean the port and cover it with a clear			F0698	Continued from page 19 centers and that care provided is consistent with professional standards. Measures put in place to ensure deficient practice does not recur: Staff education was provided on the importance of timely and effective communication with dialysis centers and adherence to professional standards of dialysis care. Effective implementation of actions will be monitored by: The Director of Nursing or designee will audit 100% of charts for residents receiving dialysis weekly for three months to ensure effective communication with dialysis centers and care consistent with professional standards. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended. The person responsible to maintain compliance is: Director of Nursing Completion date: August 4th, 2025		

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F0698 SS = D	Continued from page 20 plastic dressing to prevent infection. The CN stated staff at the care facility should not be touching the dialysis port or dressing in between dialysis runs and that the clear plastic dressing should be left in place. The CN further stated the staff at the care facility had not been communicating with the dialysis center that they were removing the clear plastic film leaving R98 vulnerable for infection, or that the clear plastic film was itching R98, stating they had other dressings they could try had they known R98 was bothered by the clear plastic dressing. During an interview on 6/25/25 at 10:53 a.m., the director of nursing (DON) stated R98's order to remove the dressing from the dialysis site was a house standing order and was not intended for a resident who had a dialysis port, but rather a fistula (a surgical connection made between an artery and a vein) which does not require a cover for infection control. The DON confirmed the dressing covering R98's dialysis port should not be removed, which put R98 at a higher risk for infection, and there was concern about collaboration with the dialysis center. A facility policy titled Dialysis, reviewed 3/10/2025, indicated "residents who require dialysis will receive this service consistent with professional standards of practice and the comprehensive person-centered plan of care" and the facility would have "ongoing communication and collaboration with the dialysis facility."		F0698				

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K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on June 24, 2025, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Apple Valley Health Care, 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. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145			K0000			08/04/2025

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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K0000	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info: AUGUSTANA HEALTHCARE CENTER OF APPLE VALLEY is a three-story building, with a full basement The building was constructed in 1983 and was determined to be of Type II (222) construction, with a full basement.		K0000				

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K0000	Continued from page 2		K0000				
K0353 SS = A	The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification.		K0353				
	The facility has a capacity of 162 beds and had a census of 147 at the time of the survey.						
	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:						
	Sprinkler System - Maintenance and Testing						
	CFR(s): NFPA 101						
	Sprinkler System - Maintenance and Testing						
	Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.						
	a) Date sprinkler system last checked						
	b) Who provided system test						
	c) Water system supply source						
	Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.						
	9.7.5, 9.7.7, 9.7.8, and NFPA 25						
	This STANDARD is NOT MET as evidenced by:						
	Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. This deficient finding could an isolated						

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K0353 SS = A	Continued from page 3 impact on the residents within the facility. Findings include: On 06/24/2025, at 8:40 AM, it was revealed by observation that storage materials had been placed within 18" of the sprinkler system within the Kitchen Freezer. On 06/24/2025, at 8:40 AM, it was revealed by observation that wires were resting on the sprinkler system in the hallway on the Lower Level and also in the Lower Level Storage Room. An interview with the Maintenance Director verified this deficient finding at the time of discovery.		K0353				
K0363 SS = F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered		K0363	K363 Brief description of corrective action or planned corrective action: The smoke control doors on the 1st floor by Room 121 and on the Lower Level by the Elevator were immediately adjusted and repaired to ensure they fully close and latch securely. Steps to prevent recurrence: All corridor and smoke control doors throughout the facility were checked for proper closure and latching. Maintenance staff were retrained on how to inspect and adjust door hardware and closing mechanisms. A schedule was established for regular physical checks of all corridor doors. How the facility plans to monitor future performance to ensure solutions are sustained: Maintenance staff will conduct weekly inspections of all corridor and smoke control doors to confirm proper operation and closure. Any issues identified during inspections will be corrected immediately and documented.		08/04/2025	

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K0363 SS = F	Continued from page 4 compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/24/2025, at 9:30 AM, it was revealed by observation that the smoke control doors on the 1st floor by Room 121 and on the Lower Level by the Elevator failed to properly close. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0363	Continued from page 4 Person responsible for compliance: Maintenance Director		07/15/2025
K0901 SS = A	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and document review, the facility did not implement a risk assessment procedure for building systems designed to meet Category 1 through 4 in accordance with NFPA 99, Chapter 4. This deficient finding could have an isolated impact on the residents within the facility			K0901			

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K0901 SS = A	Continued from page 5 Findings include: On 06/24/2025, at 8:46 AM, it was revealed that at the time of the survey, the facility was unable to provide documentation of the Facility Risk Assessment required under NFPA 99 Chapter 4. An interview with the Maintenance Director verified this deficient finding at the time of discovery.		K0901				