Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 10, 2023

Administrator
Valley View Healthcare & Rehab
510 East Cedar Street
Houston, MN 55943

RE: CCN: 245566
Cycle Start Date: May 10, 2023

Dear Administrator:

On July 5, 2023, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 12, 2023

Administrator
Valley View Healthcare & Rehab
510 East Cedar Street
Houston, MN 55943

RE: CCN: 245566
Cycle Start Date: May 10, 2023

Dear Administrator:

On May 10, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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:

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

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 August 10, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 10, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

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

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

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	C 05/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW HEALTHCARE & REHAB	510 EAST CEDAR STREET HOUSTON, MN 55943

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 5/8/23 through 5/10/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 5/8/23 through 5/10/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiencies cited: H55662111C (MN85457) 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 substantial compliance with the regulations has been attained.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8)	F 561		6/22/23

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

Electronically Signed | 06/21/2023

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

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F 561	Continued From page 1 §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a resident's preferences to keep his room door shut while unoccupied was honored for 1 of 1 resident (R17) reviewed for choices. Findings include: R17's significant change Minimum Data Set	F 561	F561 R17 care plan has been updated on 5/10/23 to include resident's preference to having door closed when he is not present. A sign was also placed outside the door on 5/10/23 to remind staff to close door when resident not present.	

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F 561	Continued From page 2 (MDS) dated 3/29/23, identified R17 was alert and oriented and had diagnoses of schizaffective disorder and mild intellectual disabilities. R17's care plan dated dated 4/28/21, identified R17 experienced delusions and hallucinations in the past. Staff were directed to encourage R17 to spend time out of his room for meals, activities; and to spend time with others. The care plan lacked any resident preferences related to R17's room door. During an interview on 5/8/23 at 1:39 p.m., R17 stated when he was not in his room he wanted to keep his door shut. R17 told social services (SS)-A this, but staff continued to leave it open. During an observation on 5/9/23 at 9:40 a.m., R17 was not in his room and his door was open. During an observation on 5/10/23 at 7:33 a.m., housekeeping (HSKG)-A was cleaning R17's room while R17 was in the dining room eating breakfast. HSKG-A did not close R17's door after cleaning R17's room. During an interview on 5/10/23 at 8:08 a.m., HSKG-A stated they did not know R17 liked to have his door shut. There was not any type of reference for resident's preferences and the only way you knew what someone liked was by getting to know the residents. During an interview on 5/10/23 at 9:08 a.m., SS-A stated R17 liked to have his door shut when he left his room and R17 had let her know that was his preference. SS-A had not communicated R17's preference to the staff. SS-A assumed when staff entered his room and the door was	F 561	All current residents in the facility will have a preference assessment completed by social services or designee. Any specific preferences will be care planned and staff will be communicated with via resident preference binder at nurses station. Risk of re-occurrence will be minimized by the Social Worker or designee initiating the following: 1) All staff will be educated on the facility policy Accommodation of Needs prior to our compliance date. Education on the policy was initiated on 6/14/23. On-call staff who have not been scheduled to work prior to our compliance date will be educated prior to their next scheduled shift. 2) 3 random resident’s preferences will be completed weekly for 3 months to ensure resident preferences are met. 5 random staff members will be interviewed weekly for 3 months to ensure they understand how resident preferences are communicated per facility policy. Audits will be ongoing until reviewed at QA and a determination is made that they are no longer necessary. 3) Audits will be brought to the QA committee quarterly to discuss findings and need for further auditing and/or additional staff training.	

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F 561	Continued From page 3 shut they would shut the door when they left. Nursing had a communication book for these things, but housekeeping did not have access to the communication book. Preferences were important because they were apart of the residents' rights and preferences should be followed to ensure a resident was satisfied with their stay. An interview with the administrator and director of nursing (DON) on 5/10/23 at 10:09 a.m., was conducted. The administrator stated staff needed a visual cue to remind them to shut R17's door and the preference should be communicated to all staff. The DON and the administrator both stated there was a communications book available for all staff and staff were expected to review entries. The administrator stated all residents had individual rights to privacy and protection of their belongings and it was not for staff to determine if those preferences were valid or invalid. The DON stated this was R17's home and should be treated as such. The facility communication book dated 7/15/21 through 5/10/23, lacked R17's preference to keep his door shut when his room was unoccupied. The facility policy Resident Rights revised 12/2016, identified employees shall treat all residents with kindness, respect and dignity. Federal laws guaranteed certain basic rights to all residents of this facility. These rights included the resident's right to: 1. Be supported by the facility in exercising his or her rights; 2. Privacy and confidentiality; 3. Voice grievances to the facility, or other agency that hears grievances, without discrimination or	F 561		

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F 561	Continued From page 4 reprisal and without fear of discrimination or reprisal; 4. Have the facility respond to his or her grievances.	F 561		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide soft bite sized food and encourage to alternate consumption of liquids and solids during meals as ordered for 1 of 1 (R2) resident of the sampled residents who had a diagnosis of dysphagia (difficulty with swallowing) and received a mechanically altered diet.	F 692	F692: Nutrition/Hydration Status Maintenance All nursing staff were educated on R2 care plan to ensure staff are encouraging resident to alternate consumption of liquids and solids during meals and having him remain sitting up right for 30 minutes	6/22/23

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F 692	Continued From page 5 Findings include: R2's undated "Face Sheet," provided by the facility, revealed an admission date of 11/16/11, with medical diagnoses which included but not limited to hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominate side, dysphagia following an unspecified cerebrovascular disease, and vascular dementia. The "Face Sheet" specified R2's most recent readmission to the facility was on 02/22/23. R2's facility-provided hospital "After Visit Summary," dated 02/22/23, revealed, " ... on further swallow evaluation he was found to have some dysphagia (was provided SB6 soft and bite-sized diet, which he continued on discharge) so cannot exclude possible mild aspiration pneumonia to explain CXR (chest x-ray) findings." R2's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 02/28/23, revealed R2 had a "Brief Interview for Mental Status (BIMS)" score of 9 of 15, which indicated moderate cognitive impairment. Per the MDS, R2 experienced coughing or choking during meals or when swallowing medications during the assessment period. R2's facility-provided current "Care Plan" revealed a "Problem" area initiated on 05/30/2018, which specified "I am at increased nutritional risk related to a history of CVA (cerebrovascular accident) with dysphagia, diabetes with a need for a therapeutic diet." Care plan approaches included "Staff will cut up my meats. I am independent with eating." and "I should be sitting upright during any	F 692	after meals. RD created “Resident Requiring Assistance/Cues at Meals” form that includes all residents that have any preference/order related resident needs for mealtime assistance. A policy titled, Mealtime Assistance, was initiated for this process. Risk of re-occurrence will be minimized by the Director of Nursing or designee initiating the following: 1) All nursing staff will be educated on the facility policy Mealtime Assistance prior to our compliance date. Education on the policy was initiated on 6/21/23. Nursing staff who have not been scheduled to work prior to our compliance date will be educated prior to their next scheduled shift. 2) 3 random resident’s requiring assistance/cues at meals will be audited weekly for 3 months to ensure residents needs are met. Audits will be ongoing until reviewed at QA and a determination is made that they are no longer necessary. 3) Audits will be brought to the QA committee quarterly to discuss findings and need for further auditing and/or additional staff training. Should a resident require assistance cutting up proteins during a meal it will be indicated on the meal ticket to alert the head cook. A policy was created entitled	

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F 692	Continued From page 6 meals/liquid consumption. Encourage me to alternate liquids and solids during mealtimes. I should remain sitting up for 30 minutes after meals." R2's "Physician's Order Report: 04/18/2023 - 06/18/2023," revealed the following orders, "Diet: Dysphagia soft bite sized/general/thin liquids" and "Resident should be encouraged to alter liquids and then solids during meals." Continuous observation on 05/08/23 from 11:55 a.m. to 12:19 p.m., revealed R2 was seated by himself at a dining room table independently eating his lunch meal. R2 was served a piece of toasted garlic bread and a cookie with his meal. The toasted garlic bread and cookie appeared to be hard and were not cut into small bite sized pieces. R2 took only a very small bite off the end of the cookie and placed it back onto his plate. R2 was not observed to attempt to eat the toasted garlic bread. During the meal R2 took multiple bites of solid food before he took a drink of liquid. R2 was not encouraged to alter solids with liquids during the meal. At 12:19 p.m., staff assisted R2 from the dining room. R2's finished lunch meal revealed he did not eat the toasted garlic bread and ate only a very small bite of the cookie he received at this meal. Observation on 05/09/23 at 12:15 p.m., revealed R2 was seated by himself at a dining room table independently eating his lunch meal. R2 was served a grilled sandwich that was not cut into bite sized pieces. The resident took multiple bites of food without taking a drink of liquid. R2 was not encouraged to alter solids with liquids during this meal observation. At 12:20 p.m., staff assisted R2 from the dining room. R2's finished lunch	F 692	"Protein Cutting Policy for Resident's Who Require Bite-Sized Protein". All cooks will be educated on the policy by the Dietary Manager prior to their next scheduled shift. The Dietary Manager will audit all tray tickets for all current residents for one week to ensure that all dietary notes, such as "encouraging alternating liquids and solids" are accurate and easy to read. The Dietary Manager will review all meal tickets for new residents before first meal service after admission. Dietary Manager or designee will observe all meal service for one week to ensure proper cutting of meat according to policy. The results of the audits will be brought to the next Quality Assurance meeting for review.	

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F 692	Continued From page 7 meal revealed he did not eat the outer portions of the grilled sandwich which appeared to have a hard texture. During an interview on 05/10/23 at 9:05 a.m., the dietary manager (DM) stated R2 had problems with swallowing and chewing and was to receive a mechanical soft diet with soft bite sized foods at meals. The DM confirmed staff should not have served R2 the toasted garlic bread and hard cookie during the 05/08/23 lunch meal or the grilled sandwich during the 05/09/23 lunch meal. The DM explained staff should have served R2 soft bread with butter instead of the toasted garlic bread, and a soft oatmeal cream pie instead of the hard cookie during the 05/08/23 lunch meal. The DM stated staff should have served R2 either a regular sandwich or a lightly grilled sandwich in place of the grilled sandwich with hard outer edges R2 received during the 05/09/23 lunch meal. During an interview on 05/10/23 at 11:10 a.m., the director of nursing (DON) confirmed staff should encourage R2 to alternate liquids with solids during meals as ordered. The DON stated that she thought R2 was being encouraged by staff to alternate solids and liquids at mealtimes. The facility-provided policy titled, "Therapeutic Diets," with a revision date of 09/17, revealed, "All residents have a diet order, including regular, therapeutic and texture modification, that is prescribed by the attending physician, physician extender of credible practitioner in accordance with applicable regulatory guidelines." ... "'Mechanically altered diet' means one in which the texture of the diet is altered. When the texture is modified, the type of texture must be specific	F 692		

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F 692	Continued From page 8 and part of the physicians' or delegated registered or licensed dietitian's order."	F 692		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by	F 801		6/26/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	C 05/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW HEALTHCARE & REHAB	510 EAST CEDAR STREET HOUSTON, MN 55943

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 801	Continued From page 9 the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers,	F 801		

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VALLEY VIEW HEALTHCARE & REHAB	510 EAST CEDAR STREET HOUSTON, MN 55943

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F 801	Continued From page 10 meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to employ either a full time registered dietitian (RD) or a qualified dietary manager (DM) to carry out the functions of the food and nutrition service since December 2022. This failure had the potential to affect all 31 residents who resided in the facility. Findings include: During an interview on 05/08/23 at 9:45 a.m., the DM stated she recently completed the Serv Safe course but was not a certified dietary manager (CDM). The DM stated the facility's registered dietitian (RD) was employed on a consultant basis and usually visited the facility once per week. During an interview on 05/10/23 at 9:05 a.m., the DM stated she worked at the facility since 2011 as a part time and full time cook prior to becoming the DM during the end of 2022. The DM stated she had not previously worked as a DM. The DM explained she was not a CDM or a certified food service manager and was not currently enrolled in a CDM course. The DM explained since December 2022 when she started working as the DM the facility's consultant RD only visited the facility about once per week. During an interview on 05/10/23 at 10:40 a.m., the administrator stated the facility's current DM	F 801	F801: Qualified Dietary Staff; Valley View contracted Healthcare Services Group to manage the dietary department. Since the completion of the survey, HCSG has hired a new Dietary Manager, Cathy Mc-Alister Previch. Cathy is a CFM with a certification in LTC and Servsafe management certification. Cathy will start on 06/26/2023. Cathy has 7 years of experience with Healthcare Services Group as a dietary manager and will be on site daily. Credentials can be provided on request. This is a permanent, on site, full time position. Cathy meets the state qualifications. Healthcare Services Group will be responsible for ensuring that the facility has qualified dietary staff.	

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	245566	A. BUILDING _____ B. WING _____	C 05/10/2023

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VALLEY VIEW HEALTHCARE & REHAB	510 EAST CEDAR STREET HOUSTON, MN 55943

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F 801	Continued From page 11 worked at the facility for many years as a cook prior to becoming the DM in December 2022. The administrator stated the current DM recently completed the Serv Safe course but was not a CDM or certified food service manager and was not currently enrolled in a CDM course. The administrator stated she thought the current DM met the required qualifications for the position based on her work experience and completion of the Serv Safe course. The administrator explained since the current DM began working in the capacity in December 2022 the facility had contracted with RDs who only worked at the facility on a consultant basis approximately one day a week and had not employed a full time RD to work at the facility. Review of the facility's policy titled, "Professional Staffing," revised 09/17, specified, "The Dining Services department will employ sufficient staff, with appropriate competencies and skills sets to carry out the functions of food and nutrition services, taking into consideration the resident assessments, individual plans of care and the number, acuity and diagnosis of the resident population. This includes a qualified dietitian or other clinically qualified nutrition professional, either full time or part time. If the qualified dietitian or other clinically qualified nutrition professional is not employed full time, a director of food and nutrition services who meets the necessary qualifications will be employed. ... A 'qualified director of food and nutrition services' is one who: Is a certified dietary manager, or, Is a certified food service manager, or Has similar national certification for food service management and safety from a national certifying body; or Has an associate's or higher degree in food service management or in hospitality, if the course of	F 801		

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F 801	Continued From page 12 study includes food service or restaurant management, from an accredited institution of higher learning, and In states that have established standards for food service manage or dietary managers meet state requirements for food service managers or dietary managers."	F 801		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to label, date, and cover food stored in kitchen refrigerator and freezer storage. The facility also failed to discard hot dogs that had signs of spoilage and left-over food stored in refrigeration for greater than seven days. This had the potential to affect 30 residents who consumed food prepared in the facility's	F 812	F812 Food Procurement, Store/Prepare/Serve All Dietary staff will be in-serviced on labeling and dating. New Healthcare Services Group signage will be posted to remind employees of proper storage techniques and instructions on when to	6/21/23

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F 812	Continued From page 13 kitchen. Findings include: 1. Observation during the initial kitchen inspection on 05/08/23 from 9:45 a.m. to 10:15 a.m., with the dietary manager (DM) present, revealed the following: a. Observation of food stored in a reach-in refrigerator, near the kitchen's tray line area, revealed one bowl of egg salad dated 04/28, six unlabeled and undated raw ground beef patties, one container of undated and unlabeled mozzarella cheese, five unlabeled and undated hard-boiled eggs, and two opened and undated 16-ounce plastic bags of whipped topping. b. Observation of food stored in a reach-in refrigerator, in the kitchen's food preparation area, revealed one container of left-over turkey slices dated 04/26, one container of left-over fruit salad dated 04/30, one container of left-over three bean salad dated 04/30, and undated cheese slices that were wrapped in plastic wrap. c. Observation of food stored in a reach-in freezer, in the kitchen's food preparation area, revealed two opened packages of hot hogs that were discolored with accumulated ice crystals that appeared freezer burnt, a pan of undated and partially covered left-over hash browns, one box of uncovered sausage links, and two packages of undated raisin bread. During an interview on 05/08/23 at 10:15 a.m., the DM confirmed the two packages of opened hot dogs stored in the kitchen's reach-in freezer were freezer burnt and should have been	F 812	discard products after refrigeration. Dietary Manager will complete cooler/freezer audits bi-weekly to check for proper storage techniques and appropriate labeling and dating. Account Manager will monitor the cooler and freezer on a daily basis as part of structured job flow. Account Manager will record findings and in-service staff as necessary.	

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F 812	Continued From page 14 discarded by staff. The DM stated when staff place food in refrigeration and freezer storage the food should be labeled, dated, and completely closed. The DM explained staff should discard any food with signs of spoilage or has not been used within seven days after being placed in refrigeration storage. Review of the facility's policy titled, "Food Storage: Cold Foods," revised on 4/18, specified, "All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent contamination." Review of the facility's policy titled, "'Use By' Dating Guidelines," revised on 12/01/15, specified, "Ready-to-eat, Time/Temperature Control for Safety Foods including, but not limited to: Milk, yogurt, cottage cheese, cheese, cooked foods, hard cooked eggs, produce, prepared salads, roasted meats, sliced meats, unused portions "Use by" date seven days after opening." ... "Meats, eggs and other frozen items that are placed in the refrigeration to thaw: ... Ground Meat ... "Use by date: 1-2 days."	F 812		
F 921 SS=F	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to keep the kitchen's small mixer, sheet pans, two kitchen drawers, and a shelf where food preparation equipment	F 921	F921; Safe/Functional/Sanitary/Comfortable Environment;	6/30/23

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F 921	Continued From page 15 was stored clean. The facility also failed to maintain the kitchen's walk-in freezer in safe operating condition by failing to prevent ice buildup inside the freezer. This failure had the potential to affect 30 residents who consumed food prepared in the facility's kitchen. Findings include: 1. Observation during the initial inspection of the facility's kitchen on 05/08/23 from 9:45 a.m. to 10:15 a.m., with the dietary manager (DM) present, revealed the following: a. The kitchen's small mixer, covered and ready for use, was unclean with dried food splatters. b. Two kitchen drawers, with food preparation equipment including: scoops, metal and rubber spatulas, serving spoons, tongs and whisks stored in them, were unclean with greasy residues and food debris. c. A kitchen shelf, with food preparation pans stored on it, was unclean with a greasy residue and food debris. d. Five of five food preparation sheet pans, stored as clean and stacked directly on top of each other, were unclean with a heavy grease residue. During an interview on 05/08/23 at 9:55 a.m., the DM confirmed the kitchen's small mixer, five sheet pans, and the interior of two drawers and a shelf where food preparation equipment was stored were unclean. The DM stated staff were expected to make sure kitchen equipment was clean prior to storing it for use.	F 921	The Dietary Manager has been working on resolving sanitation issues by following Healthcare Services Group cleaning and sanitation policies and procedures. Dietary Manager and HCSG District Manager completed a deep clean of the kitchen on 06/20/2023 and 06/21/2023. This included floors, walls, vents, stainless surfaces, drawers, cupboards, etc. The Registered Dietician will complete Sanitation Audits monthly and submit to Healthcare Services Group by the 15th of every month to ensure a safe and sanitary environment. The HSCG District Manager will complete bi-weekly audits of kitchen sanitation and cleaning schedule and will log completion. The Dietary Manager will complete daily audits of cleaning schedules/logs and sanitation of the kitchen. This audit will target areas of sanitation concerns listed in 2567, as well as overall kitchen cleanliness and sanitation. The walk in freezer was emptied on 06/19,and totally defrosted, dried out, cleaned, and sanitized. The Dietary Manager will monitor daily for ice buildup and record findings to report to the Maintenance Supervisor. Healthcare Services Group has implemented their cleaning logs and cleaning schedules to be used at Valley View. To ensure the problem does not	

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F 921	Continued From page 16 2. Observation on 05/08/23 at 10:10 a.m., with the DM present, revealed the kitchen's walk-in freezer had accumulated ice buildup on the freezer's door, door frame, floor, ceiling, shelves and on boxes of food stored inside the freezer. Areas of the freezer's floor not covered by a rubber mat were very slick. During an interview on 05/08/23 at 10:10 a.m., the DM stated the accumulated ice buildup in the kitchen's walk-in freezer was an ongoing issue. The DM stated the facility's maintenance staff were aware of the ice build up in the walk-in freezer. Observation on 05/09/23 at 9:05 a.m., revealed the kitchen's walk-in freezer had accumulated ice buildup on the freezer's door, door frame, floor, ceiling, shelves, and on boxes of food stored inside the freezer. Areas of the freezer's floor not covered by a rubber mat were very slick. During an interview on 05/09/23 at 9:05 a.m., the DM stated the dietary staff were previously directed to make sure the freezer's door was completely shut to reduce the ice buildup inside of the freezer. The DM was unaware of any plan for the walk-in freezer to be serviced or repaired. Observation on 05/10/23 at 7:15 a.m., revealed the walk-in freezer's door was not completely closed and would not latch shut. The freezer had ice buildup on the door, door frame, floor, ceiling, shelves, and on boxes of food stored inside of the freezer. Areas of the freezer's floor that were not covered by a rubber mat were very slick. Ice buildup on the freezer's door and door frame prevented the door from closing completely. Also, the door's interior gasket (which creates a tight	F 921	reoccur, audits will be done for the next six months, three times weekly, by the Dietary Manager starting 6/26/2023. Other audits of the systems will be done by the registered dietitian bimonthly, as well as the district manager bimonthly. An inservice on how to properly use the cleaning logs will be drafted and presented to the staff by 6/30/2023.	

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F 921	Continued From page 17 seal when the door is closed to keep cold air inside the freezer and outside air out) was cracked, worn, and not tightly affixed around the door. During an interview on 05/10/23 at 7:17 a.m., cook (C)-1 stated when she came into work on 05/10/23 at 5:30 a.m. the kitchen's walk-in freezer door was not completely closed and would not latch shut. Observation on 05/10/23 at 8:10 a.m., with the maintenance director (MD) present, revealed the kitchen's walk-in freezer had accumulated ice buildup on the door, door frame, floor, ceiling, shelves, and on boxes of food stored inside of the freezer. The ice buildup on freezer's door and door frame prevented the door from closing completely and the door would not latch shut. Also, the door's interior gasket was cracked, worn, and not tightly affixed around the freezer door. During an interview on 05/10/23 at 8:10 a.m., the MD stated an outside repair company checked the walk-in freezer a couple months ago regarding the ice buildup inside the freezer. The MD explained the outside repair company advised the facility to keep the freezer's door closed as much as possible to prevent ice from forming inside the freezer. The MD stated the current ice buildup inside the walk-in freezer was worse than he had previously observed. The MD agreed the ice around the freezer's door prevented the door from being completely shut and the door's gasket was cracked, poorly affixed to the door, and needed to be replaced. The MD stated he did not have a plan in place to fix the walk-in freezer because he had not received a	F 921		

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F 921	Continued From page 18 work order regarding the current ice buildup in the walk-in freezer, so he was unaware of this being an ongoing issue that needed to be addressed. Review of the facility's policy titled, "Equipment," revised on 9/17, revealed, "Policy Statement All foodservice equipment will be clean, sanitary, and in proper working order. Procedures ... 3. All food contact equipment will be cleaned and sanitized after every use. 4. All non-food contact equipment will be clean and free of debris. 5. The Dining Services Director will submit requests for maintenance or repair to the Administrator and/or Maintenance Director as needed."	F 921		

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	245566	A. BUILDING **01 - VALLEY VIEW NURSING HOME** B. WING _____	**05/08/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW HEALTHCARE & REHAB	**510 EAST CEDAR STREET HOUSTON, MN 55943**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/08/2023. At the time of this survey, VALLEY VIEW HEALTHCARE & REHAB was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 06/21/2023

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

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	245566	A. BUILDING **01 - VALLEY VIEW NURSING HOME** B. WING _____	**05/08/2023**

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VALLEY VIEW HEALTHCARE & REHAB	**510 EAST CEDAR STREET HOUSTON, MN 55943**

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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. VALLEY VIEW HEALTHCARE & REHAB is a 1 story building with no basement. The building was constructed at 4 different times. The original building was constructed in 1957, with additions following in 1976, 1988, and 2011. All to be determined as Type II (111). The original building and all additions have no basement.	K 000		

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	245566	A. BUILDING **01 - VALLEY VIEW NURSING HOME** B. WING _____	**05/08/2023**

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K 000	Continued From page 2 Because the original building and addition meet the construction type allowed for existing buildings, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, that is monitored for automatic fire department notification. There is an assisted living facility which is separated from the nursing home by a 2 hour fire separation. The facility has a capacity of 40 beds and had a census of 31 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 271 SS=E	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain facility discharge from	K 271	K271 Discharge from Exits CFR(s): NFPA 101	6/14/23

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K 271	Continued From page 3 exits per NFPA 101 (2012 edition), Life Safety Code sections 19.2.1, 7.1.6.1.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 05/08/2023 between 10:00 AM and 2:00 PM, it was revealed by observation that the West building exit exhibited a vertical drop of more than 1 inch from the threshold of the door to the concrete walkway and surface patching material was degrading. 2. On 05/08/2023 between 10:00 AM and 2:00 PM, it was revealed by observation that the South Activities Room exit exhibited a vertical drop of more than 1 inch from the threshold of the door to the concrete walkway. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 271	The concrete on by the west building exit with a vertical drop of more than 1 inch from the threshold of the door was removed on 06/03/2023. New concrete was poured on 06/07/2023 correcting the 1-inch drop. The concrete on by the South Activities Room exit with a vertical drop of more than 1 inch from the threshold of the door was removed on 06/03/2023. New concrete was poured on 06/07/2023 correcting the 1-inch drop. Maintenance Supervisor will inspect all exits quarterly and document conditions. Any thresholds that exhibit more than a 1-inch drop will reviewed at the next quarterly QA meeting and Safety Meeting and corrected with appropriate measures as recommended by an outside contractor.	
K 291 SS=C	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain emergency lighting testing documentation per NFPA 101 (2012 edition), Life Safety Code, section 19.2.9.1, 7.9, and 7.9.3.1.1(5). This deficient finding could have a widespread impact	K 291	K291 Emergency Lighting CFR(s): NFPA 101 All Emergency Lights were numbered with a label maker and the locations identified on a facility map. A new form was	6/14/23

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K 291	Continued From page 4 on the residents within the facility. Findings include: On 05/08/2023 between 10:00 AM and 2:00 PM, it was revealed by review of available documentation that it was unclear when the monthly and annual testing occurred. An interview with Maintenance Director verified this deficient finding at the time of discovery.	K 291	developed clarifying the date that the Emergency Lights were tested, along with a column for any failures or repairs needed. Emergency Lights will be tested by the Maintenance Supervisor monthly. The results of the testing will be reported at the next quarterly QA meeting following the testing date.	
K 353 SS=D	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 the sprinkler system in accordance with NFPA 101 (2012 edition), Life	K 353	K353 Sprinkler System □ Maintenance and Testing CFR9s): NFPA 101	6/14/23

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K 353	Continued From page 5 Safety Code, sections 9.7.5, 9.7.6 and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 5.2.1.1.1, 5.2.1.1.2(2)(5). These deficient findings could have an isolated impact on the residents within the facility. Findings include: On 05/08/2023 between 10:00 AM and 2:00 PM, it was revealed by observation that the sprinkler heads located in the Kitchen Receiving Corridor and within the Kitchen exhibited signs of debris loading and oxidation. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 353	Sprinkler heads in the kitchen area that showed signs of corrosion were replaced on 05/19/2023 by Summit Fire Protection. Summit Fire Protection inspects the sprinkler system quarterly. Inspection findings are emailed to the maintenance supervisor. In addition, the Maintenance Supervisor will spot check sprinkler heads monthly for signs of corrosion. Maintenance Supervisor will direct Summit Fire Protection to replace sprinkler heads with signs of corrosion. The results of the spot checks, along with the quarterly sprinkler inspection, will be reviewed at the next quarterly QA meeting following the inspection.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general	K 920		6/14/23

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K 920	Continued From page 6 precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to manage the usage of relaocatable power taps in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, and NFPA 70, (2011 edition), National Electrical Code, sections 110.3(B), 400.8 (1) and UL 1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 05/08/2023 between 10:00 AM and 2:00 PM, it was revealed by observation, that in the Kitchen Office, an appliance (refrigerator) was connected to a relocatable power tap. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 920	K920 Electrical Equipment □ Power Cords and Extens CFR(s): NFPA 101 Power strip located in the dietary office was removed on Monday, May 8th, the day of the inspection. An electrician installed an additional outlet in the dietary office. All managers were educated on 06/14/2023 that any power strips used in an office must be approved by the Maintenance Supervisor for proper usage. The Maintenance Supervisor will monitor offices monthly to ensure there is no improper usage of power strips. Findings will be reviewed at the Quarterly QA meeting to ensure and review compliance.	
K 926 SS=F	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety	K 926		6/22/23

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K 926	Continued From page 7 guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation the facility failed to confirm that a medical gas training program is in use per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.5.2.1 through 11.5.2.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/08/2023 between 10:00 AM and 2:00 PM, it was revealed by a review of available documentation that no documentation was presented for review to confirm that a medical gas training program is currently in use by the facility. An interview with Director of Nursing verified this deficient finding at the time of discovery.	K 926	K926 Risk of re-occurrence will be minimized by the Director of Nursing or designee initiating the following: 1) Director of Nursing will be educated by facility RN Nurse Consultant on the facility policy Oxygen Administration prior to our compliance date. Education included the requirement of medical gas training program, including oxygen competency forms to be completed per policy. All nursing staff (Licensed Nurses, Trained Medication Aides, and Nursing assistants) will have an oxygen competency completed by our compliance date. On-call nursing staff who have not been scheduled to work prior to our compliance date will complete competency prior to their next scheduled shift. All nursing staff (Licensed Nurses, Trained Medication Aides, and Nursing assistants) will be audited to ensure they have completed Oxygen Administration and Safety education within the past year. Nursing staff (Licensed Nurses, Trained Medication Aides, and Nursing assistants) who have not completed Oxygen Administration and Safety education within the past year will be required to complete by our compliance date. On-call staff who have not been scheduled to	

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K 926	Continued From page 8	K 926	work prior to our compliance date will be educated prior to their next scheduled shift. 2) 3 nursing employee files will be randomly audited weekly for 3 months to ensure an oxygen competency has been completed. 3 nursing employee files will be randomly audited weekly for 3 months to ensure the employee has completed Oxygen Administration and Safety education per policy. Audits will be ongoing until reviewed at QA and a determination is made that they are no longer necessary. 3) Audits will be brought to the QA committee Quarterly to discuss findings and need for further auditing and/or additional staff training.	