Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 17, 2024

Administrator
Chosen Valley Care Center
1102 Liberty Street Southeast
Chatfield, MN 55923

RE: CCN: 245423
Cycle Start Date: July 12, 2024

Dear Administrator:

On August 26, 2024, 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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 17, 2024

Administrator
Chosen Valley Care Center
1102 Liberty Street Southeast
Chatfield, MN 55923

Re: Reinspection Results
Event ID: D6LK12

Dear Administrator:

On August 26, 2024, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 12, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 31, 2024

Administrator
Chosen Valley Care Center
1102 Liberty Street Southeast
Chatfield, MN 55923

RE: CCN: 245423
Cycle Start Date: July 12, 2024

Dear Administrator:

On July 12, 2024, 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:

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, Minnesota 55901
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727

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 October 12, 2024 (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 January 12, 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) / 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:

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,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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Electronically delivered
July 31, 2024

Administrator
Chosen Valley Care Center
1102 Liberty Street Southeast
Chatfield, MN 55923

Re: State Nursing Home Licensing Orders
Event ID: D6LK11

Dear Administrator:

The above facility was surveyed on July 8, 2024, through July 12, 2024, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, Minnesota 55901
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/09/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/09/2024. At the time of this survey, CHOSEN VALLEY CARE CENTER 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	K 000		

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

Electronically Signed | 08/06/2024

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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CHOSEN VALLEY CARE CENTER	**1102 LIBERTY STREET SOUTHEAST** **CHATFIELD, MN 55923**

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K 000	Continued From page 1 IS NOT REQUIRED. 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. CHOSEN VALLEY CARE CENTER - BLDG 01 is a 1 story building with no basement. Building 01 was constructed at three different times. The original building was constructed in 1975 and was determined to be of Type V (111) construction. In 1998, an addition was constructed	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CHOSEN VALLEY CARE CENTER	**1102 LIBERTY STREET SOUTHEAST** **CHATFIELD, MN 55923**

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K 000	Continued From page 2 and was determined to be of Type V (111) construction. In 2001, an addition was constructed and was determined to be of Type II (000) construction. In 2002, a canopy was constructed and was determined to be of Type V (111) construction. In 2020-2021 extensive remodel and reconstruction occurred to Building 01. 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. The building is attached to Building 02, an addition constructed in 2020 which was determined to be of Type V(111) construction. There is a 2-hour fire-rated wall separating the two buildings and will therefore be surveyed as two buildings. The facility has a capacity of 78 beds and had a census of 77 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72	K 345		8/23/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 345	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to secure and maintain documentation per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1, 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 14.4.5.3, 14.4.5.3.2. This deficient finding could have an widespread impact on the residents within the facility. Findings include: On 07/09/2024 between 11:30 AM and 3:30 PM, it was revealed by a review of available documentation that no detailed fire alarm sensitivity report was available for review. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 345	The facility is in compliance with this regulation. Records verifying sensitivity testing of the smoke detectors by Eagan Electrical were provided to the State Fire Marshal. To comply with the request for a more detailed report, a representative from Eagan Electric will visit the facility and download more detailed facility-specific smoke detector sensitivity information. Eagan Electric plans to provide the additional information by August 14, 2024. A detailed report will be requested from the contractor with each subsequent smoke detector sensitivity testing. The Maintenance Director will be responsible for monitoring compliance with the detailed report required verifying smoke alarm sensitivity testing.	
K 353 SS=F	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	K 353		8/23/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOSEN VALLEY CARE CENTER	**1102 LIBERTY STREET SOUTHEAST CHATFIELD, MN 55923**

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K 353	Continued From page 4 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 inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 5.2, 5.2.1.1.2, 5.2.2.2 These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 07/09/2024 between 11:30 AM and 3:30 PM, it was revealed by observation that sprinkler head(s) located in the Kitchen / Dishwashing areas exhibiting signs of oxidation. 2. On 07/09/2024 between 11:30 AM and 3:30 PM, it was revealed by observation that in the Main Boiler Room cabling was found attached to the sprinkler system piping. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	All the sprinkler heads in the kitchen will be replaced by the Summit Fire Protection by August 16, 2024. The cable attached to the sprinkler system piping in the Main Boiler Room was removed July 23, 2024. The Maintenance Director will be responsible for monitoring the condition of the sprinkler heads and related piping. Inspection of the sprinkler heads and piping will be added to a routine maintenance log and be included in the monthly building safety committee rounds.	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with	K 355		8/5/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 355	Continued From page 5 NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, review of available documentation and staff interview, the facility failed to properly inspect, and maintain documentation of portable fire extinguishers in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.2.4.1, 7.2.4.3, 7.2.4.4, 7.2.4.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 07/09/2024 between 11:30 AM and 3:30 PM, it was revealed by a review of available documentation, records were found to be incomplete in content and inspection sign-off. 2. On 07/09/2024 between 11:30 AM and 3:30 PM, it was revealed by observation and random inspection of fire extinguishers that not all devices were current in monthly inspections. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 355	A map of the facility and outbuildings with locations of fire extinguishers designated with a numbered x and a corresponding monthly log with a numbered list of all extinguishers have been developed. Use of the map and the log will ensure that all fire extinguishers are located and tested monthly. The Maintenance Director/designee will verify and sign the fire extinguisher test reports. An annual fire extinguisher inspection will continue to be completed and signature verified by Summit Fire Protection. The Maintenance Director/designee will be responsible for monitoring compliance with required fire extinguisher inspections.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke	K 372		8/5/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 372	Continued From page 6 dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to maintain and inspect smoke barrier construction per NFPA 101 (2012 edition), Life Safety Code, sections 19.3, 19.3.2, 19.3.7.3, 8.3.5, 8.3.5.6 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/09/2024 between 11:30 AM and 3:30 PM, it was revealed by observation that in RM 316 there was a missing ceiling tile which revealed a damaged section of gypsum board of the smoke barrier construction. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 372	The damaged section of the smoke barrier gypsum board in room 316 has been overlaid with 5/8 inch fire rated sheet rock and sealed with taping compound and intumescent fire barrier caulk. Inspection of overhead smoke barriers in the halls will be completed on a rotating basis during the monthly building safety rounds. Smoke barrier integrity will also be inspected after any construction/repair which may penetrate the barrier with pipes, wiring, cables, etc. The Maintenance Director will monitor compliance of smoke barrier integrity by inspecting smoke barriers during the routine building safety rounds and after any construction/repair which poses a risk of penetrating the smoke barrier.	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per	K 374		8/23/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/09/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 374	Continued From page 7 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to test, maintain and inspect the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7 and 8.5.4 These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 07/09/2024 between 11:30 AM and 3:30 PM, it was revealed by observation that in Wing 300 smoke barrier doors, adjacent to RM 52, exhibited an air-gap(s) greater than 1/8 inch, which would allow the passage of smoke 2. On 07/09/2024 between 11:30 AM and 3:30 PM, it was revealed by observation that in Wing 200 smoke barrier doors, adjacent to RM 59, exhibited an air-gap(s) greater than 1/8 inch, which would allow the passage of smoke An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 374	Johnson Hardware Company has been contacted regarding adjusting the gap in the smoke barrier doors to 1/8 inch or less. Johnson Hardware plans to complete the adjustment by August 19, 2024. All smoke barrier doors will be inspected to ensure a gap of 1/8 inch or less. Monitoring of gaps in the smoke barrier doors will be included in the monthly building safety inspection rounds; any gaps found greater than 1/8 inch will be adjusted. The Maintenance Director will monitor compliance with the smoke compartment door barrier requirements.	
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with	K 511		8/5/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/09/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 511	Continued From page 8 NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to secure electrical panels in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.5.1.1 and 9.1.2, NFPA 99 (2012 edition), section 6.3.2.2.1.3(A), NFPA 70 (2011 edition), National Electrical Code, section 110.26(A)(F), 110.27(A)(1), 225.19(C) These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 07/09/2024 between 11:30 AM and 3:30 PM, it was revealed by observation that in RM 56 that cardboard boxes were found stacked and positioned in front of electrical panels. 2. On 07/09/2024 between 11:30 AM and 3:30 PM, it was revealed by observation that electrical panels (L3-L & L3-R) in the resident corridor adjacent to the Central Nurses Station were found unsecured. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 511	The boxes obstructing the front of the electrical panel in room 56 have been removed. As a reminder to staff to maintain clearance in front of the electrical panel, the area in front of the boxes will be outlined with tape. The staff will be instructed that the area is to remain unobstructed and placing items with the area designated by tape is prohibited. The electrical panels (L3-L and L3-R) in the resident corridor adjacent to the Central Nurses Station have been secured. All other electrical panels have been inspected and found to have been securely locked. The Maintenance Director/designee will be responsible for monitoring compliance with clearance in front of electrical panels and the security of the electrical panels.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101	K 914		8/5/24

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	245423	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/09/2024**

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

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K 914	Continued From page 9 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to identify a plan of action for electrical receptacle testing in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2, 6.3.4, 6.3.4.1.3, 6.3.4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/09/2024 between 11:30 AM and 3:30 PM, it was revealed by review of available documentation that documentation was presented for review identified that annual electrical outlet testing was	K 914	The facility has a procedure for annual electrical receptacle testing-the most recent testing on July 7, 2024 was completed 368 days after the 2023 tests. To facilitate timely equipment inspection and testing, the facility will be subscribing to TELS, a software program that tracks preventive maintenance tasks and equipment testing schedules. The program can be modified to meet facility-specific needs. Alerts are sent to the maintenance and administrative staff when tests/inspections are due. The Administrator/designee will monitor compliance with the timeliness of the	

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	245423	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/09/2024**

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

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K 914	Continued From page 10 last completed on 07/07/2023. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 914	required annual electrical receptacle testing.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders.	K 923		8/5/24

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	245423	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/09/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 923	Continued From page 11 When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 9.3.7, 11.6.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 07/09/2024 between 11:30 AM and 3:30 PM, it was revealed by observation in the Med Gas (O2) Storage Room there was mixed storage of empty / full cylinders. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 923	The facility has policies and procedures for separate storage of empty and full oxygen cylinders. The designated storage areas are marked. The nursing staff will be reminded of the oxygen related facility procedures and regulatory requirements including separate storage of full and empty cylinders. Additional signage will be installed to facilitate appropriate storage of full and empty cylinders in the separate designated areas. The Maintenance Director will be responsible for monitoring compliance. Safe oxygen storage will be monitored during the routine monthly building safety inspections for three months and then randomly thereafter. If noncompliance is noted, more frequent audits and additional staff education will be done.	

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	245423	A. BUILDING **02 - 102 LIBERTY STREET** B. WING _____	**07/09/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 07/09/2024. At the time of this survey, CHOSEN VALLEY CARE CENTER 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	K 000		

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

Electronically Signed | 08/06/2024

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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	245423	A. BUILDING **02 - 102 LIBERTY STREET** B. WING _____	**07/09/2024**

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K 000	Continued From page 1 IS NOT REQUIRED. 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. CHOSEN VALLEY CARE CENTER - BLDG 02 is a 1 story building with no basement. Building 02 was an addition to the facility that was constructed in 2020 and was determined to be of Type V (111) construction. The building is protected by a full fire sprinkler	K 000		

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	245423	A. BUILDING **02 - 102 LIBERTY STREET** B. WING _____	**07/09/2024**

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CHOSEN VALLEY CARE CENTER	**1102 LIBERTY STREET SOUTHEAST CHATFIELD, MN 55923**

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K 000	Continued From page 2 system. The facility has a fire alarm system with full corridor smoke detection, resident rooms and spaces open to the corridors that are monitored for automatic fire department notification. The building is attached to (Building 01) a 1-story building with no basement. Building 01 was constructed at 3 different times. The original building was constructed in 1975 and was determined to be of Type V(111) construction. In 1998, an addition was constructed and was determined to be of Type V(111) construction. In 2001, an addition was constructed and was determined to be of Type II(000) construction. In 2002, a canopy was constructed and was determined to be of Type V(111) construction. There is a 2-hour fire rated wall separating the two buildings and will therefore be surveyed as two buildings. The facility has a capacity of 78 beds and had a census of 77 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.	K 345		8/23/24

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	245423	A. BUILDING **02 - 102 LIBERTY STREET** B. WING _____	**07/09/2024**

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K 345	Continued From page 3 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to secure and maintain documentation per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1, 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 14.4.5.3, 14.4.5.3.2. This deficient finding could have an widespread impact on the residents within the facility. Findings include: On 07/09/2024 between 11:30 AM and 3:30 PM, it was revealed by a review of available documentation that no detailed fire alarm sensitivity report was available for review. An interview with the Maintenance Director verified thls deficient finding at the time of discovery.	K 345	The facility is in compliance with this regulation. Records verifying sensitivity testing of the smoke detectors by Eagan Electrical were provided to the State Fire Marshal. To comply with the request for a more detailed report, a representative from Eagan Electric will visit the facility and download more detailed facility-specific smoke detector sensitivity information. Eagan Electric plans to provide the additional information by August 14, 2024. A detailed report will be requested from the contractor with each subsequent smoke detector sensitivity testing. The Maintenance Director will be responsible for monitoring compliance with the detailed report required verifying smoke alarm sensitivity testing.	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, review of available documentation and staff interview, the facility failed to properly inspect, and maintain documentation of portable fire extinguishers in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers,	K 355	A map of the facility and outbuildings with locations of fire extinguishers designated with a numbered x and a corresponding monthly log with a numbered list of all extinguishers have been developed. Use of the map and the log will ensure that all fire extinguishers are located and tested	8/5/24

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K 355	Continued From page 4 section 7.2.4.1, 7.2.4.3, 7.2.4.4, 7.2.4.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 07/09/2024 between 11:30 AM and 3:30 PM, it was revealed by a review of available documentation, records were found to be incomplete in content and inspection sign-off. 2. On 07/09/2024 between 11:30 AM and 3:30 PM, it was revealed by observation and random inspection of fire extinguishers that not all devices were current in monthly inspections. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 355	monthly. The Maintenance Director/designee will verify and sign the fire extinguisher test reports. An annual fire extinguisher inspection will continue to be completed and signature verified by Summit Fire Protection. The Maintenance Director/designee will be responsible for monitoring compliance with required fire extinguisher inspections.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 NEW Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations of fully ducted HVAC systems. 18.3.7.3, 18.3.7.4, 18.3.7.5, 8.3 Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to maintain and inspect smoke barrier construction per NFPA 101 (2012 edition), Life Safety Code,	K 372	The damaged section of the smoke barrier gypsum board in room 316 has been overlaid with 5/8 inch fire rated sheet rock	8/5/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 372	Continued From page 5 sections 19.3, 19.3.2, 19.3.7.3, 8.3.5, 8.3.5.6 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/09/2024 between 11:30 AM and 3:30 PM, it was revealed by observation that in the Mechanical Room - RM 447 there were penetrations and missing fire chalking in the walls of the room. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 372	and sealed with taping compound and intumescent fire barrier caulk. Inspection of overhead smoke barriers in the halls will be completed on a rotating basis during the monthly building safety rounds. Smoke barrier integrity will also be inspected after any construction/repair which may penetrate the barrier with pipes, wiring, cables, etc. The Maintenance Director will monitor compliance of smoke barrier integrity by inspecting smoke barriers during the routine building safety rounds and after any construction/repair which poses a risk of penetrating the smoke barrier.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to one month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing	K 914		8/5/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING **02 - 102 LIBERTY STREET** B. WING _____	**07/09/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 914	Continued From page 6 date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to identify a plan of action for electrical receptacle testing in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2, 6.3.4, 6.3.4.1.3, 6.3.4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/09/2024 between 11:30 AM and 3:30 PM, it was revealed by review of available documentation that documentation was presented for review identified that annual electrical outlet testing was last completed on 07/07/2023. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 914	The facility has a procedure for annual electrical receptacle testing-the most recent testing on July 7, 2024 was completed 368 days after the 2023 tests. To facilitate timely equipment inspection and testing, the facility will be subscribing to TELS, a software program that tracks preventive maintenance tasks and equipment testing schedules. The program can be modified to meet facility-specific needs. Alerts are sent to the maintenance and administrative staff when tests/inspections are due. The Administrator/designee will monitor compliance with the timeliness of the required annual electrical receptacle testing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/09/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/09/2024. At the time of this survey, CHOSEN VALLEY CARE CENTER 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	K 000		

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

Electronically Signed | 08/06/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/09/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 IS NOT REQUIRED. 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. CHOSEN VALLEY CARE CENTER - BLDG 01 is a 1 story building with no basement. Building 01 was constructed at three different times. The original building was constructed in 1975 and was determined to be of Type V (111) construction. In 1998, an addition was constructed	K 000		

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	245423	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/09/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 and was determined to be of Type V (111) construction. In 2001, an addition was constructed and was determined to be of Type II (000) construction. In 2002, a canopy was constructed and was determined to be of Type V (111) construction. In 2020-2021 extensive remodel and reconstruction occurred to Building 01. 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. The building is attached to Building 02, an addition constructed in 2020 which was determined to be of Type V(111) construction. There is a 2-hour fire-rated wall separating the two buildings and will therefore be surveyed as two buildings. The facility has a capacity of 78 beds and had a census of 77 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72	K 345		8/23/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/09/2024**

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CHOSEN VALLEY CARE CENTER	**1102 LIBERTY STREET SOUTHEAST** **CHATFIELD, MN 55923**

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K 345	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to secure and maintain documentation per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1, 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 14.4.5.3, 14.4.5.3.2. This deficient finding could have an widespread impact on the residents within the facility. Findings include: On 07/09/2024 between 11:30 AM and 3:30 PM, it was revealed by a review of available documentation that no detailed fire alarm sensitivity report was available for review. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 345	The facility is in compliance with this regulation. Records verifying sensitivity testing of the smoke detectors by Eagan Electrical were provided to the State Fire Marshal. To comply with the request for a more detailed report, a representative from Eagan Electric will visit the facility and download more detailed facility-specific smoke detector sensitivity information. Eagan Electric plans to provide the additional information by August 14, 2024. A detailed report will be requested from the contractor with each subsequent smoke detector sensitivity testing. The Maintenance Director will be responsible for monitoring compliance with the detailed report required verifying smoke alarm sensitivity testing.	
K 353 SS=F	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	K 353		8/23/24

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	245423	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/09/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 4 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 inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 5.2, 5.2.1.1.2, 5.2.2.2 These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 07/09/2024 between 11:30 AM and 3:30 PM, it was revealed by observation that sprinkler head(s) located in the Kitchen / Dishwashing areas exhibiting signs of oxidation. 2. On 07/09/2024 between 11:30 AM and 3:30 PM, it was revealed by observation that in the Main Boiler Room cabling was found attached to the sprinkler system piping. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	All the sprinkler heads in the kitchen will be replaced by the Summit Fire Protection by August 16, 2024. The cable attached to the sprinkler system piping in the Main Boiler Room was removed July 23, 2024. The Maintenance Director will be responsible for monitoring the condition of the sprinkler heads and related piping. Inspection of the sprinkler heads and piping will be added to a routine maintenance log and be included in the monthly building safety committee rounds.	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with	K 355		8/5/24

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	245423	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/09/2024**

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

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K 355	Continued From page 5 NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, review of available documentation and staff interview, the facility failed to properly inspect, and maintain documentation of portable fire extinguishers in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.2.4.1, 7.2.4.3, 7.2.4.4, 7.2.4.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 07/09/2024 between 11:30 AM and 3:30 PM, it was revealed by a review of available documentation, records were found to be incomplete in content and inspection sign-off. 2. On 07/09/2024 between 11:30 AM and 3:30 PM, it was revealed by observation and random inspection of fire extinguishers that not all devices were current in monthly inspections. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 355	A map of the facility and outbuildings with locations of fire extinguishers designated with a numbered x and a corresponding monthly log with a numbered list of all extinguishers have been developed. Use of the map and the log will ensure that all fire extinguishers are located and tested monthly. The Maintenance Director/designee will verify and sign the fire extinguisher test reports. An annual fire extinguisher inspection will continue to be completed and signature verified by Summit Fire Protection. The Maintenance Director/designee will be responsible for monitoring compliance with required fire extinguisher inspections.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke	K 372		8/5/24

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	245423	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/09/2024**

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CHOSEN VALLEY CARE CENTER	**1102 LIBERTY STREET SOUTHEAST** **CHATFIELD, MN 55923**

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K 372	Continued From page 6 dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to maintain and inspect smoke barrier construction per NFPA 101 (2012 edition), Life Safety Code, sections 19.3, 19.3.2, 19.3.7.3, 8.3.5, 8.3.5.6 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/09/2024 between 11:30 AM and 3:30 PM, it was revealed by observation that in RM 316 there was a missing ceiling tile which revealed a damaged section of gypsum board of the smoke barrier construction. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 372	The damaged section of the smoke barrier gypsum board in room 316 has been overlaid with 5/8 inch fire rated sheet rock and sealed with taping compound and intumescent fire barrier caulk. Inspection of overhead smoke barriers in the halls will be completed on a rotating basis during the monthly building safety rounds. Smoke barrier integrity will also be inspected after any construction/repair which may penetrate the barrier with pipes, wiring, cables, etc. The Maintenance Director will monitor compliance of smoke barrier integrity by inspecting smoke barriers during the routine building safety rounds and after any construction/repair which poses a risk of penetrating the smoke barrier.	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per	K 374		8/23/24

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K 374	Continued From page 7 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to test, maintain and inspect the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7 and 8.5.4 These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 07/09/2024 between 11:30 AM and 3:30 PM, it was revealed by observation that in Wing 300 smoke barrier doors, adjacent to RM 52, exhibited an air-gap(s) greater than 1/8 inch, which would allow the passage of smoke 2. On 07/09/2024 between 11:30 AM and 3:30 PM, it was revealed by observation that in Wing 200 smoke barrier doors, adjacent to RM 59, exhibited an air-gap(s) greater than 1/8 inch, which would allow the passage of smoke An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 374	Johnson Hardware Company has been contacted regarding adjusting the gap in the smoke barrier doors to 1/8 inch or less. Johnson Hardware plans to complete the adjustment by August 19, 2024. All smoke barrier doors will be inspected to ensure a gap of 1/8 inch or less. Monitoring of gaps in the smoke barrier doors will be included in the monthly building safety inspection rounds; any gaps found greater than 1/8 inch will be adjusted. The Maintenance Director will monitor compliance with the smoke compartment door barrier requirements.	
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with	K 511		8/5/24

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	245423	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/09/2024**

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K 511	Continued From page 8 NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to secure electrical panels in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.5.1.1 and 9.1.2, NFPA 99 (2012 edition), section 6.3.2.2.1.3(A), NFPA 70 (2011 edition), National Electrical Code, section 110.26(A)(F), 110.27(A)(1), 225.19(C) These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 07/09/2024 between 11:30 AM and 3:30 PM, it was revealed by observation that in RM 56 that cardboard boxes were found stacked and positioned in front of electrical panels. 2. On 07/09/2024 between 11:30 AM and 3:30 PM, it was revealed by observation that electrical panels (L3-L & L3-R) in the resident corridor adjacent to the Central Nurses Station were found unsecured. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 511	The boxes obstructing the front of the electrical panel in room 56 have been removed. As a reminder to staff to maintain clearance in front of the electrical panel, the area in front of the boxes will be outlined with tape. The staff will be instructed that the area is to remain unobstructed and placing items with the area designated by tape is prohibited. The electrical panels (L3-L and L3-R) in the resident corridor adjacent to the Central Nurses Station have been secured. All other electrical panels have been inspected and found to have been securely locked. The Maintenance Director/designee will be responsible for monitoring compliance with clearance in front of electrical panels and the security of the electrical panels.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101	K 914		8/5/24

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K 914	Continued From page 9 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to identify a plan of action for electrical receptacle testing in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2, 6.3.4, 6.3.4.1.3, 6.3.4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/09/2024 between 11:30 AM and 3:30 PM, it was revealed by review of available documentation that documentation was presented for review identified that annual electrical outlet testing was	K 914	The facility has a procedure for annual electrical receptacle testing-the most recent testing on July 7, 2024 was completed 368 days after the 2023 tests. To facilitate timely equipment inspection and testing, the facility will be subscribing to TELS, a software program that tracks preventive maintenance tasks and equipment testing schedules. The program can be modified to meet facility-specific needs. Alerts are sent to the maintenance and administrative staff when tests/inspections are due. The Administrator/designee will monitor compliance with the timeliness of the	

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K 914	Continued From page 10 last completed on 07/07/2023. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 914	required annual electrical receptacle testing.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders.	K 923		8/5/24

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	245423	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/09/2024**

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

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K 923	Continued From page 11 When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 9.3.7, 11.6.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 07/09/2024 between 11:30 AM and 3:30 PM, it was revealed by observation in the Med Gas (O2) Storage Room there was mixed storage of empty / full cylinders. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 923	The facility has policies and procedures for separate storage of empty and full oxygen cylinders. The designated storage areas are marked. The nursing staff will be reminded of the oxygen related facility procedures and regulatory requirements including separate storage of full and empty cylinders. Additional signage will be installed to facilitate appropriate storage of full and empty cylinders in the separate designated areas. The Maintenance Director will be responsible for monitoring compliance. Safe oxygen storage will be monitored during the routine monthly building safety inspections for three months and then randomly thereafter. If noncompliance is noted, more frequent audits and additional staff education will be done.	

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	00750	A. BUILDING: _____ B. WING _____	C 07/12/2024

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/8/2024-7/12/2021, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed during the survey: H54235285C (MN00087588). NO licensing orders were issued. H54235286C (MN00097052). NO licensing orders were issued. H54235287C (MN00085381). NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading	2 000		

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2 000	Continued From page 2 completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to resume restorative services for 1 of 2 residents (R4) reviewed for	2 895	Corrected	8/22/24

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2 895	Continued From page 3 limited range of motion . Findings include: R4's significant change Minimum Data Set (MDS) assessment, dated 6/15/24 indicated R4 as cognitively intact with no behaviors or rejection of cares, limited upper and lower range of motion to one side, and dependent on staff for activities of daily living (ADLs) R4's diagnoses list included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (limited to no movement following stroke), chronic pain, central pain syndrome (pain as the result in brain injury), muscle weakness, repeated falls, and neurologic neglect syndrome (a disorder that causes the body to favor one side over the other after injury to the brain). During an interview on 7/9/2024 at 8:52 a.m., R4 stated she has not participated in exercises or therapy for at least 2-3 weeks. R4 stated she would like to do exercises to increase her chances of going home. R4's care plan dated 3/1/24, indicated impaired mobility, dependent on staff for transferring, repositioning, and ADL's. A progress note dated 6/17/2024 indicated, "her [R4] progress is not quite at the skilled level." "Her progress seems more at the restorative level than the skilled level so please make therapy aware ..." During interview on 7/11/2024 at 10:13 a.m., rehab tech-C stated R4 is not currently receiving physical or occupational therapy (OT). She	2 895		

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2 895	Continued From page 4 stated R4 was discharged from physical therapy on 5/20/24 and occupational therapy on 6/8/24 due to returning to her prior level of functioning. Restorative programs are set up by the therapy department with tasks performed by a therapy and facility restorative tech. Rehab tech-C stated there was no active restorative program for R4. During interview on 7/11/24 at 10:14 a.m., restorative tech-D stated R4 had been on a restorative program however, he was unsure why it ended. Indicating programs are kept and documented in a binder. He confirmed the binder lacked a program for R4. The restorative tech stated the therapy department monitors the restorative program in conjunction with the restorative nurse (CM-A) During interview on 7/11/24 at 11:03 a.m., the therapy director stated R4 had an active restorative program until a recent hospitalization. She assumed the program would restart upon R4's return from the hospital. The therapy director confirmed the program should have been restarted however was not. A physical therapy evaluation discharge summary dated 5/20/2024 indicated "Restorative range of motion program established: seated lex [lower extremities] ROM exs [exercises]". A Therapy Communication to Nursing form dated 11/10/2023 indicated exercises as follows: 1. Stand in stand aide/white frame for 1-5 minutes as tolerated-will need to assist LUE (left upper extremity) to remain on bar to prevent leaning 2. AAROM (active assisted range of motion) of LUE-all joints	2 895		

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2 895	Continued From page 5 3. AROM (active range of motion) (AAROM if necessary to due to shoulder pain) of RUE (right upper extremity)-all joints. R4's restorative progress notes dated 12/15/23 indicated R4 was started on restorative program and listed specific exercise for R4 to perform. Restorative progress notes dated 3/29/24 indicated changes to R4's restorative program. Progress notes dated 5/10/24 indicated R4's restorative program was discontinued due to R4 working with skilled therapy and would be reevaluated upon completion of skilled therapy. During interview on 7/11/2024 at 11:45 a.m., CM-A stated restorative programs are established by therapy upon admission and discharge from therapy programs. Therapy gives restorative recommendations on a restorative therapy communication form. CM-A stated R4 had been on a restorative program however was put on hold due to starting skilled therapy 5/10/24. She stated therapy did not give any recommendations following end of skilled services and confirmed she did not follow up with therapy. CM-A stated she changed how she follows up with therapy to ensure restorative programs are restarted if appropriate. During interview on 7/11/2024 at 3:20 p.m., the director of nursing stated restorative programs are established by therapy and then monitored by CM-A. She stated she would have expected therapy and CM-A to follow up with restorative program. A restorative policy from MED-PASS revised July 2017 indicates: "Residents will receive restorative nursing care as needed to help promote optimal safety and independence. policy interpretation	2 895		

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2 895	Continued From page 6 and implementation. Restorative nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitative services. Residents may be started on a restorative program upon admission, during the course of stay or when discharged from rehabilitative care. Restorative goals and objectives are individualized and resident-centered, and are outlined in the resident's plan of care. Restorative goals may include, but are not limited to supporting and assisting the resident in: A. adjusting or adapting to changing abilities B. developing, maintaining, or strengthening his/her physiological and psychological resources. C. maintaining his/her dignity, independence and self-esteem and participating in the development and implementation of his/her plan of care. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review all residents at risk for limited range of motion to assure they are receiving the necessary treatment/services to prevent further limitation in range of motion. The director of nursing or designee, could conduct random audits of the delivery of care to ensure appropriate care and services are implemented. The results of the audits could be brought to the quality assurance committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
21330	MN Rule 4658.0725 Subp. 2 A&B Providing Routine & Emergency Oral Health Ser Subp. 2. Annual dental visit.	21330		8/22/24

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21330	Continued From page 7 A. Within 90 days after admission, a resident must be referred for an initial dental examination unless the resident has received a dental examination within the six months before admission. B. After the initial dental examination, a nursing home must ask the resident if the resident wants to see a dentist and then provide any necessary help to make the appointment, on at least an annual basis. This opportunity for an annual dental checkup must be provided within one year from the date of the initial dental examination or within one year from the date of the examination done within the six months before admission. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to arrange dental services after a non-urgent/routine dental referral was placed for 1 of 1 residents (R36) reviewed for dental concerns. Findings include: R36's quarterly Minimum Data Set (MDS) assessment, dated 5/12/24, identified moderately impaired cognition with medical diagnoses of diabetes mellitus (DM), hyperlipidemia, seizure disorder or epilepsy, depression, and medically complex conditions. R36 required extensive assistance for most activities of daily living (ADL's) and R36 was usually understood. R36 was identified as having a life expectancy of greater than six months. R36's care plan, edited 5/3/24, identified R36	21330	Corrected	

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21330	Continued From page 8 wears upper and lower dentures and needs help to cleanse them. R36 was seen during an in house contracted dental services for his annual exam on 4/24/24, and there was no need for a dental referral at this time. R36 will be seen yearly and as needed. Interventions included oral and denture care and placement daily as well as arrangement of a dental consultation when needed. R36's oral health screening form, dated 4/24/24, identified R36 had full upper denture and no lower denture. Oral/dental status identified inflamed or bleeding gums or loose natural teeth. Recommendations indicated a routine dental referral to address residents non-urgent dental care needs. It is also noted to nursing staff for follow up/care conference that R36 is interested in having spaces filled/new lower denture. R36's dental assessment progress note, dated 4/26/24 noted the dental referral was made and awaiting response from responsible party to proceed. R36's care conference note, dated 5/22/24 indicated resident, his wife (responsible party), and his daughter (emergency contact) were in attendance along with facility staff. R36's diet was noted as regular texture and consistency with no concentrated sweets and no added salt. It was noted that care plan was reviewed. There was no mention of dental screening or referral. Master Patient list dated 5/22/24 includes R36's name and date of birth. This list is to be returned to Community Care Coordinator (CCC)-H with any discharges or deceased status updates. The facility policy, titled Dental Services indicates	21330		

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21330	Continued From page 9 a social services representative will assist residents with appointments, transportation arrangements, and all dental services provided are recorded in the resident's medical record. During interview on 7/9/24 at 11:18 a.m., R36 stated he would like to have his teeth checked. He denied any current pain. He could not recall when he last saw a dentist and did not believe he has seen a dentist since his admission to the facility 5/7/21. During interview on 7/11/24 at 11:52 a.m., resident representative (RR)-I stated R36 had not talked about seeing a dentist and she had not heard anything from the facility staff about a dental referral. RR-I stated she would consider new lower dentures to ease his mind and thinks this may be a good idea. During interview on 7/12/24 at 9:06 a.m., CCC-H stated R36 has not been seen as a patient by the dentist. R36 has been seen in the facility by a hygienist for an oral health screening. CCC-H would speculate R36 wishes to be seen as a patient. CCC-H stated when the box is checked on the screening form, indicating a routine referral is recommended, the facility then needs to complete additional paperwork includes resident medical history, insurance, and privacy information and sends this to her. After CCC-H receives this paperwork, she then calls the resident, guardian, or responsible party to schedule the exam and cleaning and determine any additional treatment needed. CCC-H stated there are times in which the hygienist will mark the referral box and the resident may not be ready to take the next step in which the resident would need to let the facility know they would like to proceed with scheduling.	21330		

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21330	Continued From page 10 During interview on 7/12/24 at 11:03 a.m., Licensed Practical Nurse (LPN)-A stated after a dental visit, the screening form is given to the nurse. The nurse puts a note in the resident's electronic health record (EHR) and places the form in the resident's hard chart. If a referral is needed LPN-A would make a copy of the form and give the copy to the case manager and they take it from there. During interview on 7/12/24 at 11:12 a.m., case manager (CM)-B stated after a dental screening the form is charted and then brought to the case manager. If the resident is a current patient with the dentist, the dentist will put them on the list to be seen. If the resident is not a current patient, they (facility staff) will reach out to the number one contact and get paperwork completed and sent to dentist. If it is an urgent issue, they would let the family know that they need to be seen and they will assist with arrangements for an appointment. CM-B stated a routine referral is generally checked for a cleaning and is considered non-urgent, and they do not get worried about routine referrals. CM-B was not aware of the policy regarding dental cleanings and believes it may be required every 6 months and depends on when they last had a cleaning. CM-B did not believe the screenings counted as a cleaning and were more of an oral evaluation to determine if there are additional needs. During interview on 7/12/24 at 11:23 a.m., with Director of Social Services (DSS) stated all residents are seen by hygienist annually for MDS regardless of active concerns or not. dentist then reaches out to the responsible party if there is a referral or any type of need for follow up. DSS stated R36 is on the list of an active patients of	21330		

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21330	Continued From page 11 theirs so the dentist would handle all steps after the visit. DSS stated after the documentation is put in the resident's EHR the paperwork is placed in a subfile after she has given a copy to the case managers. DSS stated they (facility staff) do not handle any of the scheduling or follow up if the resident is an active/current patient of dentist. DSS stated the lack of progress with this referral is on the dentist end. The dentist are in the facility monthly and would prioritize the residents' needing visits based on urgency and they usually see 7-8 residents each visit/month and includes independent living (IL) and assisted living (AL) residents as well. During interview on 7/12/24 at 12:15 p.m., Director of Nursing (DON) stated she believed if the dentist made a referral they also made the arrangements for the follow up appointment or services needed. DON stated they should be following up to ensure the recommendations are being followed if the resident or their representative agrees with the plan of care. DON stated this is important to ensure continuity of care and they will be looking into this further to see what changes are needed for their current process. During interview on 7/12/24 at 12:33 p.m., DSS stated she contacted CCC-H and they determined the list of active dental patients was incorrect, and dentist does not have R36 listed as an active patient. DSS believed the resident was an active patient because he is on the list they receive from the dentist to confirm as current residents. DSS stated CCC-H informed her this was an error on their end. DSS stated will be going through the list to ensure no additional errors are present.	21330		

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	00750	A. BUILDING: _____ B. WING _____	C 07/12/2024

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21330	Continued From page 12 SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could review applicable policies on dental assessment and, if needed, appointment coordination to ensure timely and thorough completion; then inservice appropriate staff and audit to ensure ongoing compliance. TIME FRAME FOR CORRECTION: Twenty-one (21) Days	21330		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement enhanced barrier precautions (EBP) for 1 of 1 (R53) resident reviewed for infection prevention related to presence of peripherally inserted central catheter (PICC) line (a tube inserted in the arm that ends in a blood vessel in the chest). Findings include: R53's admission Minimum Data Set (MDS) assessment dated 6/25/24 indicated R53 was cognitively intact. It further indicated presence of a central IV (intravenous) access and antibiotics. R53's diagnoses list included infection to internal right knee prosthesis (artificial joint), sepsis	21375	Corrected	8/22/24

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21375	Continued From page 13 (infection in blood stream) methicillin susceptible staphylococcus aureus infection (type of bacteria), adjustment and management of vascular access device. R53's orders dated 6/21/24 included PICC line dressing change every 7 days, cefazolin sodium (antibiotic) use 3 grams intravenously three times a day for blood [stream] infection until 7/18/24, sodium chloride intravenous solution 0.9%. Use 10 ml intravenously three times a day for blood stream infection until 7/18/24. Flush 5 before and after medication. A hospital discharge summary dated 6/18/24 indicated "follow-up with ortho ID (infectious disease) near the completion of the six-week course of cefazolin therapy on July 18th 2024." "Central catheter management at the end of treatment: can be removed at the end of IV antimicrobials.". During observation on 7/9/2024 at 9:39 a.m., a PICC line was noted in R53's right upper arm. R53's room lacked any indication of enhanced barrier precautions or personal protective equipment (PPE). During observation on 7/10/24 at 10:27 a.m., a nurse was observed performing hand hygiene and putting on gloves prior to entering R53's room. R53's room did not have additional PPE or signage indicating EBP was required for R53 prior to performing cares. Intravenous antibiotic was administered without the use of enhanced barrier PPE. During interview on 7/11/2024 at 11:45 a.m., the	21375		

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21375	Continued From page 14 infection preventionist (CM-A) stated residents are screened at the time of admission and readmission for the initiation of enhanced barrier precautions. CM-A stated residents who have indwelling medical devices, chronic hard to heal wounds, catheters, and multidrug resistant organizations are required to be on precautions. After reviewing guidance from Centers for Medicare and Medicaid, CM-A confirmed R53 should have been placed on enhanced barrier precautions due to having a PICC line. CM-A stated EBP are necessary to protect residents at higher risk of infections from contracting or spreading infection to others. During an interview on 7/11/24 at 3:21 p.m., the director of nursing stated facility staff discussed EBP for PICC lines at length upon R53's admission to the facility and should have erred on the side of caution until they could clarify the regulation. An Enhanced Barrier Precautions policy dated August 2022 indicates enhanced barrier precautions are indicated "when contact precautions do not otherwise apply for residents with wounds and/or indwelling medical devices regardless of MDRO colonization". A handwritten addendum on the policy indicates "No including PICC" and "chronic complex" both dated 4/12/24 with CM-As initials. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review revise policies and procedures on infection control practices. The DON or designee could educate all staff on these policies and procedures. The DON or designee could audit	21375		

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21375	Continued From page 15 infection control practices and take the results of those audits to the Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21375		