Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 21, 2023

Administrator
Renvilla Health Center
205 Southeast Elm Avenue
Renville, MN 56284

RE: CCN: 245554
Cycle Start Date: September 7, 2023

Dear Administrator:

On September 7, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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 December 7, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 7, 2024 (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
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245554	A. BUILDING _____ B. WING _____	C 09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENVILLA HEALTH CENTER	205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 9/5/23 through 9/7/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 9/5/23 through 9/7/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H55544698C (MN89799) and H55544767C (MN91632). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 692	Nutrition/Hydration Status Maintenance	F 692		10/13/23

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

Electronically Signed | 09/29/2023

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

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F 692 SS=D	Continued From page 1 CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively assess, and create and implement interventions for ongoing undesired weight loss for 1 of 1 (R7) reviewed for significant weight loss. Findings include: R7's 9/6/23, resident face sheet identified R7 was admitted to the facility on 7/10/23. R7 had the following diagnoses a history of left hip fracture, adjustment disorder with depressed mood, age-related osteoporosis, hypertension, amnesia, seizures, and dementia.	F 692	Weight monitoring program policy was reviewed and staff education provided. R7 was reassessed for weight loss. Care plan was reviewed and revised to reflect the recommendations per assessment and evaluation. Monitoring, interventions, and documentation completed of resident intake, supplements, foods offered, and weight status. Staff will be educated on interventions and monitoring for resident weight loss. All other residents with a weight loss of	

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F 692	Continued From page 2 R7's 8/8/23, significant Minimum Data Set (MDS) assessment identified R7 had severe cognitive deficit, was independent with eating after set up assistance. R7 had physical behaviors towards others, had behaviors that significantly affected her cares and impacted others. R7 took a daily antipsychotic medication and had no identified swallowing or chewing problems. R7's 7/10/23, Service Plan (care plan) identified R7 was independent with eating and should continue to be independent after set up assistance. The staff were to offer R7 foods and drinks per R7's preference. R7 will brush her own existing teeth with a soft brush in the morning and evening during cares. R7 had partials but did not wear them. Review of 7/27/23, certified dietary manager (CDM) 5 day nutritional assessment with the assessment reference date (ARD) of 7/17/23, the CDM identified R7's weight was 104 pounds, R7 had a regular diet and no supplements at the time. R7 was pleasantly confused. CDM identified R7 was as risk for weight loss and dehydration and would care planned R7 to increase fluid intake at meals, offer drinks after toileting program, and increase snacks and possible supplements. There was no mention of these interventions on the care plan. Review of 8/7/23, CDM Significant Change Nutritional Assessment identified R7's weight at 101 pounds. R7 remained on a regular diet and started supplement 2 ounces three times a day. R7 continued to be independent with eating after set up assistance, R7 was identified to be confused and combative at times. R7 was at risk	F 692	5% or more in 30 days or 10% in 189 days have the potential to be affected by this deficient practice. The residents identified will be evaluated and assessed for appropriate weight management. Care plans will be reviewed and revised to reflect the recommendations per assessment and evaluation. Monitoring, interventions, and documentation completed of intake, supplements, foods offered, and weight status. Staff will be educated on interventions and monitoring for residents with weight loss. The CDM will document the care plans were reviewed and updated per progress note for each ARD and as needed with any nutritional changes. Audit process initiated 10/2/23 @ 3 x week x 3 weeks, then 1 x week x 2 weeks, then monthly x 2 months. The Certified Dietary Manager and/or Designee will be responsible to monitor for compliance. QAPI committee with review audits to ensure compliance and make any recommendations.	

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F 692	Continued From page 3 for weight loss and dehydration, R7 slept through meals and refused meals. The assessment identified care plan changes included increase fluid intake at meals, offer drinks after toileting program, increase snacks and possible supplement. There was no change to the care plan interventions, and no mention of these intervention on the care plan. Review of R7's weights since admission on 7/10/23: 7/10/23-103.9 pounds (lbs) 7/11/23-102.8 lbs. 7/12/23-103.8 lbs. 7/19/23-104 lbs. 7/25/23-101.6 lbs. 8/25/23-96.6 lbs. 8/25/23-89.2 lbs. 8/31/23-90.8 lbs. 8/31/23-90.8 lbs. Between 7/10/23 and 8/31/23, R7 had a 12.61% weight loss, with no interventions implemented. Observation on 9/6/23 at 8:33 a.m., of R7 in dining room sitting at table eating her breakfast independently. She then starts to leave wheeling herself away from the table, she had a couple bites of scrabbled eggs left, and some sausage. There was a medication staff at medication cart about 4 feet from her and a staff person charting off to the side of the dining area however, no staff attempted to stop her to encourage her to finish her breakfast. Interview on 9/6/23 at 8:51 a.m., with cook (C)-A identified she normally gave R7 small portions because if she gave her to much on her plate in the morning she would not eat as R7 seemed to get overwhelmed. So if she gave her small	F 692		

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F 692	Continued From page 4 portions she would eat everything on her plate and not leave the table. She also reported R7 normally would not come out for lunch or eat lunch. She stated they brought her out for lunch yesterday but she would not eat anything she just sat there. Observation 9/6/23 at 11:53 a.m., R7 was sleeping in her room in her recliner, others are all in the dining area seated at the table for lunch. At 12:21 p.m., R7 continues to be in her room sleeping in her recliner during noon meal. At 12:40 p.m., R7 was seated at the table in dining room not eating, there was no staff encouraging her to eat. Interview on 9/6/23 at 1:52 p.m., with CDM identified when there was a new admission she would completed an assessment within 5 days. The Dietician then would review the admission assessment, and she would complete the annually, and significant changes assessment or assess a resident upon request. The CDM revealed that the dietician had not reviewed R7 yet related to being ill the last time she was scheduled to come to the facility and she had to work remotely. She reported that R7 had been admitted to the facility under weight and the family had reported to her that R7 did not like to drink supplements. She reported she had started the dietary assessment and nutritional risk assessment for R7 in the electronic medical record with the review date of 7/17/23, however she had not completed either of them and they both still showed "in progress", she stated she did assess R7 though and just made a progress note. She monitored weights weekly and was aware R7 had been loosing weight. She stated she had been monitoring R7's intake about every	F 692		

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F 692	Continued From page 5	F 692		

other day reporting that R7 did well with drinking her fluids so she had dietary give her vanilla ensure in her milk when she ate breakfast but did not have that documented anywhere. She confirmed she had not started R7 on any type of supplement, she stated the doctor had not even referred R7 to the dietician at all. When asked if she had contacted the dietician about R7's weight loss she reported she had contacted her 2 days ago and had no record of that as she had just called the dietician. There was no indication the kitchen staff were fortifying her food for extra caloric intake.

Interview on 9/6/23 on 4:36 p.m., with dietician identified she was unaware of R7's weight loss and had not been notified of R7's weight loss. She identified she would expect to be notified any time a resident was loosing weight either by a phone call or email as she could make a recommendation to the facility or she could contact the provider with a recommendation. She reported she does admission assessments, and annual assessment when she comes to the facility for her visits. For issues that arise between those times that need addressing sooner she was contacted and could complete an assessment remotely if she has access. She agreed that R7's weight loss was significant and the provider should be updated and interventions put into place.

Interview on 9/7/23 at 8:25 a.m., with trained medication aide (TMA)-A identified R7 ate independently and normally ate a good breakfast but did not eat lunch unless she ate her dessert. TMA-A revealed R7 did not get any supplements that she was aware of and staff did not do anything for her to get her to eat as she eats

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F 692	Continued From page 6 independently when she wants to eat. Interview on 9/7/23 at 9:18 a.m., with registered nurse(RN)-B identified nursing does weights on bath days, then dietary reviews those weights. Staff can see other weights when they enter the weight into the computer system and if they note a change they should be reporting that to the charge nurse. If a resident was noted to be having a weight loss nursing would notify the provider as well as talk with the dietary manager to see what else we could be doing to help prevent additional weight loss. She was unaware that R7 had a significant weight loss. Interview on 9/7/23 at 10:26 a.m., with director of nursing identified that nursing completes weights weekly, dietary should monitoring weights weekly, and if a resident was loosing weight an assessment should have been completed to find out the root cause of the weight loss and implement interventions to prevent further weight loss. Review of 1/18/21, Weight Monitoring Program policy identified a significant weight loss was of 5% or more in 30 days or 10% in 189 days. The staff were to monitor for weights to maintain or improve a residents overall health. Staff would weight residents weekly, weights would be tracked and assessed once entered into the electronic health record. Residents with weight loss or risk of weight loss should be discussed at interdisciplinary team (IDT) and identify interventions. The registered dietician would be notified of all new admission, hospital returns with identified changes in conditions that may affect weight so interventions could be implements. The provider would be contacted for any significant	F 692		

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F 692	Continued From page 7 weight changes and care plans should reflect interventions implemented.	F 692		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure hair nets were accessible prior to entry for visitors and staff for 1 of 1 kitchenette. The facility also failed to ensure 1 of 1 walk-in freezer, 1 of 1 walk-in refridgerator, 2 of 2 stand alone refrigerators temperatures were consistently monitored and 1 of 2 stand alone refrigerator outside of the kitchen and 1 of 1 walk-in refrigerator was kept clean and free of food-like debris. In addition, the facility also failed to ensure food was not stored on the floor in 1 of 1 dry food storage area, scoops were not stored	F 812	Hair covering policy was reviewed and staff education provided. All residents have the potential to be affected by these deficient practices. Hairnets are accessible at the entrance of the kitchen, kitchenette and serving areas. All staff were educated that hairnets must be worn upon entrance to these areas. Audit process initiated 10/2/23 @ 3 x week x 3 weeks, then 1 x week x 2 weeks, then monthly x 2 months. The	10/13/23

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F 812	Continued From page 8 in 1 of 2 bulk containers, and 1 of 1 dishwasher temperature was consistently monitored. Findings include: Observation, interview, and document review on 9/5/23 at 10:00 a.m., with the certified dietary manager (CDM) on initial tour identified a log was hung outside of both the walk-in freezer and the walk-in refrigerator. On those logs were 2 documented temperatures (both within normal range). 3 of the 5 days had no temperatures logged. The CDM revealed that had been a known concern of getting staff to log the temperatures daily as required. Inside the walk-in refrigerator there was a spill of pink juice-like substance just below the box marked "chicken", located on the bottom shelf approximately the size of a pie plate. The floor inside the walk-in refrigerator was observed to be sticky while walking on it. The CDM stated the cook should have cleaned up any spills immediately. Observation of the dry storage area identified a box of potatoes was sitting on the floor next to the storage rack. The CDM picked the box up and carried it into the walk-in refrigerator. She agreed food was not to be stored on the floor. The bulk flour container was noted to have the scoop stored in the container sitting in the flour. The CDM removed the scoop stated staff were aware they were not to leave scoops food items. In the washing machine room was a hot temperature washing machine. Staff were to log temperatures during each wash cycle. The log had 1 temperature noted for the month of September. Observation on 9/5/23 at 11:35 a.m., of the refrigerator on the Centennial wing found a temperature log hanging on the outside of the	F 812	Certified Dietary Manager and/or Designee will be responsible to monitor for compliance. QAPI committee with review audits to ensure compliance and make any recommendations. Temperature logs of the walk-in freezer, walk in refrigerator, and stand-alone refrigerators will be documented twice per day. The dishwasher temperature will be monitored and documented at each meal. Staff were educated on documenting on the log, acceptable temperature ranges, and what to do when out of range parameters. Audit process initiated 10/2/23 @ 3 x week x 3 weeks, then 1 x week x 2 weeks, then monthly x 2 months. The Certified Dietary Manager and/or Designee will be responsible to monitor for compliance. QAPI committee with review audits to ensure compliance and make any recommendation. Walk-in freezer, walk in refrigerator, and stand-alone refrigerators were cleaned to ensure no items were on the floor, no spills, and scoops were not stored in bulk containers. Staff were educated on proper cleaning and storage of food and scoops. Audit process initiated 10/2/23 @ 3 x week x 3 weeks, then 1 x week x 2 weeks, then monthly x 2 months. The Certified Dietary Manager and/or Designee will be responsible to monitor for compliance. QAPI committee with review audits to ensure compliance and make any recommendations.	

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	245554	A. BUILDING _____ B. WING _____	C 09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENVILLA HEALTH CENTER	205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 9 refrigerator with 4 of the 5 days documented. Inside the refrigerator there was observed to be a red juice-like substance spilled on the bottom and the sides of the refrigerator wall. There were no hairnets accessible at the Centennial kitchenette serving area. There was a yellow sign hanging on the paper towel holder above the sink to notify staff to "Make sure to wear your hairnet". When asked, staff were unable to locate or recall where hairnets were stored. Observation on 9/6/23 at 11:00 a.m., of the South nurses station refrigerator identified a temperature log outside of the refrigerator. Only 1 documented temperature was recorded for month of September. Further review of the July, August, and September 2023, temperature logs for the walk-in freezer identified: 8 out of 31 days in July,no temperatures documented as having been monitored. 8 out of 31 days in August had no temperatures documented as having been monitored, and 2 out of 5 days in September had no temperatures documented as having been monitored. Further review of the July, August, and September 2023, temperature logs for the walk-in refrigerator identified: 8 out of 31 days in July had no temperatures documented as having been monitored. 8 out of 31 days in August had no temperatures documented as having been monitored, and 2 out of 5 days in September had no temperatures documented as having been monitored. Review of the July, August, and September 2023, temperature log for Centennial wing refrigerator	F 812		

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F 812	Continued From page 10 identified 17 out of 31 days in July had no temperatures documented as having been monitored, 2 out of 31 days in August had no temperature documented as having been monitored, and 1 out of 5 days in September had no temperature documented as having been monitored. Review of the July, August, and September 2023, temperature log for South nurses station refrigerator identified 4 out of 31 days in July had no temperatures documented as having been monitored, 11 out of 31 days in August had no temperature documented as having been monitored, and 3 out of 6 days in September had no temperature documented as having been monitored. Further review of July, August, and September 2023, temperature log for the dishwasher identified: 1/31 morning shift and 31/31 PM shift in July had no temperatures documented as having been monitored, 1/31 morning shift and 31/31 PM shifts in August had no temperature documented as having been monitored, and 4/5 morning shifts and 5/5 PM shifts in September had no temperature documented as having been monitored. Review of 8/27/23 through 9/2/23, Daily Cleaning/Duty Sheet identified staff were to wipe out the refrigerator in Centennial serving area and record refrigerator and freezer temperatures. There was no mention of a cleaning task in the kitchen area. Interview on 9/6/23 at 4:36 p.m., with the registered dietician identified she would expect dietary staff would maintain a sanitary	F 812		

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F 812	Continued From page 11 department, keeping the refrigerators clean, not leave scoops in bulk stock foods, ensure there was no food stored on the floor, log temperatures in all refrigerators and freezers daily, and log dishwasher temperature to ensure appropriate monitoring occurred with each wash. There was to be a cleaning schedule for routine cleaning, but staff were expected to maintain sanitation should a spill occur. Review of undated, Hair Covering policy identified all exposed hair, such as facial and hair on staff's head, was to be covered in order to prevent hair from contaminating food or clean dishes. There was no mention hairnets should be accessible at the entrances of the kitchen or the kitchenette serving areas.	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		10/13/23

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	245554	A. BUILDING _____ B. WING _____	C 09/07/2023

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F 880	Continued From page 12 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.	F 880		

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F 880	Continued From page 13 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to appropriately clean and disinfect 1 of 2 Master Care Integrity Bath with Reservoir tubs per the manufacture's guidelines using a wet contact time of 10 minutes with an approved chemical. This had the potential to effect 41 of 41 residents who used the Master Care tubs. Findings include: Observation and interview on 9/6/23 at 10:36 a.m., with nursing assistant (NA)-A as she took the attached sprayer and rinsed the tub and chair surfaces with water and allowed to drain from the tub, She then closed the tub drain, turned on the jets, filled the tub to the intake value, turned on the disinfectant switch to allow the disinfectant/cleaner to flow into the tub, and used a scrub brush to scrub all interior surfaces of the tub and bath chair. NA-A turned off the jets and drained the solution from the tub. She again closed the drain, reached to the side of the Master Care jetted tub, turned the panel button for the attached manufacturer's disinfectant located beside the tub and using the attached sprayer, sprayed the tub and bath chair surfaces, she then took the scrub brush and scrubbed the tub and chair surfaces with disinfectant and removed the chair cushion to allow cleaning of	F 880	When notified of the infection control issue on 9/6/23, ADON immediately put the two tubs 'out of order' and cleaned the tubs according to manufacturer's recommendations. All residents are at risk for this deficient practice. Directions on how to properly disinfect the tubs were provided to all staff on 9/6/2023 per manufactures guidelines. Updated directions were also posted by tubs. Tub cleaning policy was reviewed and updated to include directions to follow the disinfectants' recommendations for disinfecting tub. Nursing and housekeeping department education and competency completed by 10/6/23. Audit process initiated 9/26/23 @ 1 x week x 4 weeks, then every other week x 2 months, then monthly x 2 months. Director of Nursing/designee responsible to monitor for compliance. QAPI committee with review audits to ensure compliance and make any recommendations.	

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F 880	Continued From page 14 the bottom surfaces. NA-A sprayed the disinfectant over the tub and chair and reported she would wait 10 minutes and then return to rinse the tub. The surface of the tub sides and upright chair surface was observed drying and were dry at 10:51 a.m., when NA-A reported she could now open the drain and rinse the tub and chair surfaces with water to get rid of the disinfectant that was on the surface, and it was ready for the next bath. NA-A reported staff were to clean the tub after each bath and a there was an additional cleaning and disinfecting process completed after the last bath was given. She referred to the cleaning and disinfecting instructions posted on the wall beside the tub which listed to let the disinfectant sit on the tub surfaces for at least 10 minutes. She reported she followed the directions to make sure the tub was clean and disinfected and was not aware of a need to keep the tub and chair surfaces wet for disinfection, only that it needed to be on the surface for 10 minutes. Interview on 9/6/23 at 11:00 a.m., with the infection preventionist (IP)/assistant director of nursing (ADON) reported staff had been reeducated on cleaning and disinfecting the Master Care tubs, after being cited last year, but she was not aware of the manufacture's label directions on the disinfectant solution that identified the required wet time of 1 to 10 minutes for disinfection depending on the organism. The ADON agreed that the disinfectant was not being used per the manufacture's guidelines. Interview on 9/6/23 at 11:45 a.m. with the director of nursing (DON) reported staff had received education on how to clean and disinfect the Master Care tub and review of the Master Care	F 880		

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F 880	Continued From page 15 integrity Bath with reservoir System Operation procedures listed to open the drain and after standard contact time per label directions on disinfectant container, use the Shower Wand to rinse all areas that had contact with the disinfectant cleaner. She reported she was not aware of the need for surfaces to remain wet for 1 to 10 minutes as directed on the disinfectant label. Interview on 9/07/23 at 11:01 a.m., with the environmental services supervisor reported he had contacted the Master Care company about the brand of whirlpool disinfectant and cleaner being used in the facility. He reported they did not specify a specific brand of disinfectant to be use in the Master Care jetted tubs, but the label directions should be followed to ensure disinfection was completed. Review of the manufacturer's System Operation Procedures identified the Master Care Integrity Bath with Reservoir System disinfection was to be used according to the standard contact time on the label of the disinfectant container. The Classic Whirlpool Disinfectant and Cleaner label identified after using the whirlpool unit, staff were to drain and refill with fresh water to the level of covering the intake valve. Staff were to add 2 ounces of the disinfectant for each gallon of fresh water added. Staff were to then start the pump to circulate the solution and wash down the unit sides, seat of the chair, lift and any/all related equipment with a clean swab, brush, or sponge. Treated surfaces were to remain wet for 10 minutes. After the unit had been thoroughly cleaned, staff were to drain the solution from the unit and rinse any/all cleaned surfaces with fresh water.	F 880		

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	245554	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/06/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENVILLA HEALTH CENTER	**205 SOUTHEAST ELM AVENUE** **RENVILLE, MN 56284**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 09/06/2023. At the time of this survey, Renvilla Health Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/29/2023

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Renvilla Health Center was built in 1963, with building additions constructed in 1970 and 1993. This one-story with partial basement facility is fully fire sprinkler protected. The original building and 1970 addition were determined to be of Type II (III) construction. The 1993 addition was determined to be a type V (III) construction due to a wood roof deck. In the 2008, a resident wing addition was built. It is one-story, has a partial basement, is fully fire sprinkler protected and was determined to be of Type II(III) construction.	K 000		

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	245554	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/06/2023**

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K 000	Continued From page 2 Surveyed as one building. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 50 beds and had a census of 41 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain clear path of egress per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, 19.2.3.4, 19.2.3.5 and 7.1.10.1. These deficient findings could have a isolated impact on the residents within the facility. Findings include: On 09/06/2023 at 11:00 AM, it was revealed by observation there is combustible storage of kitchen supplies in the egress corridor from the kitchen.	K 211	Storage was removed from the egress corridor by the kitchen and will maintain a clear path of egress. Staff educated on the need to keep egress corridor path clear at all times. Director of Environmental Services and/or designee will audit to ensure compliance. Audits will be conducted 3 x week x 4 weeks, then 1 x week x 12 weeks. QAPI committee will review audits to ensure compliance and make any recommendations.	10/13/23

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K 211	Continued From page 3 An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 211		
K 232 SS=F	Aisle, Corridor, or Ramp Width CFR(s): NFPA 101 Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the egress corridor width per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.3.4 and 19.2.3.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 09/06/2023 at 11:30 AM, observation reveled the following findings: 1) Interior finish materials mounted on corridor walls in the 100 Wing and 200 Wing have diminished the width of these existing corridors. The original corridor width of 82 1/4-inches has been reduced at various points along the entire length of the corridors by as little as one-inch [between the aluminum siding on one side to the lap siding on the opposite side) to as much as 5	K 232	FSES survey will be conducted with a passing score.	10/20/23

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RENVILLA HEALTH CENTER	**205 SOUTHEAST ELM AVENUE** **RENVILLE, MN 56284**

(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 232	Continued From page 4 1/4-inches [between the faux tree trunk on one side to the frame of the faux window on the other side. 2) Grab rails mounted on corridor walls of the 100 Wing and 200 Wing project between 5-inches and 5 1/2-inches into the corridors, as measured from the original gypsum wall board to the outside edges of the wooden rails. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 232		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
November 8, 2023

Administrator
Renvilla Health Center
205 Southeast Elm Avenue
Renville, MN 56284

RE: CCN: 245554
Cycle Start Date: September 7, 2023

Dear Administrator:

On October 16, 2023, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
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Email: Kamala.Fiske-Downing@state.mn.us