



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 3, 2025

Administrator
Valley View Manor HCC
200 East Ninth Avenue
Lamberton, MN 56152

RE: CCN: 245378
Cycle Start Date: May 14, 2025

Dear Administrator:

On May 14, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Nicole Dahl, RN, Regional Operations Supervisor

Marshall District Office

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 August 14, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 14, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

Valley View Manor HCC

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<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

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

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

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

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112



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June 3, 2025

Administrator
Valley View Manor HCC
200 East Ninth Avenue
Lamberton, MN 56152

Re: State Nursing Home Licensing Orders
Event ID: GIQZ11

Dear Administrator:

The above facility was surveyed on May 12, 2025 through May 14, 2025 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

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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:

Nicole Dahl, RN, Regional Operations Supervisor

Marshall District Office

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

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.

Sincerely,



Kamala Fiske-Downing

Compliance Analyst | Federal Enforcement

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Office: 651-201-4112

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

PRINTED: 06/30/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245378	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/14/2025
NAME OF PROVIDER OR SUPPLIER VALLEY VIEW MANOR HCC			STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments On 5/12/25 through 5/14/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000			
F 000	INITIAL COMMENTS On 5/12/25 through 5/14/25, 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: H53784087 (MN104729) and H53784088C (MN103942). 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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/12/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See 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 554 SS=F	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to determine whether a resident was safe to self-monitor diabetic medication treatment results (blood glucose levels) for 1 of 1 residents (R13) who had a continuous blood glucose monitoring system (FreeStyle 3 Libre). Findings include: Observation and interview on 5/14/25 at 8:15 a.m., with R13 identified she had a sensor on the back of her arm and a hand held meter. She placed the meter near the sensor and it recorded her blood glucose level. She identified the nurse would come in and ask her what her blood sugar is and she would tell them. "If my blood sugar is low they give me orange juice or a snack". R13 was not aware of any time that she would need to do a manual blood sugar check and was not familiar with how the alarms worked on the device. Review of R13's Self Administration of Medications assessment did not identify R13 had been given any guidance or assessed to ensure she was knowledgeable on how to use the monitor or when she would need to complete a manual blood glucose check to ensure accuracy. Interview on 5/14/25 at 1:04 p.m., with the assistant director of nursing (ADON) identified the	F 554	R13 had a new self-administration of medications completed and the MD was contacted for medication review. From the MD review, R13's orders will be processed and implemented. R13 care plan will be reviewed and updated as needed. Currently, there are no other residents who are self-administering their medication. Continuous Glucose Monitoring Machines will no longer be used at this facility. Future residents who request self-administration of their medications will have an assessment performed, the IDT along with the MD will, based on this review determine if a self-administration order and care plan will be implemented. The IDT team and Licensed Nurses will be in-serviced on the Self-Administration of Medication policy with emphasis on item #1 that the IDT assesses the cognitive and physical ability to determine if a resident is safe to self-administer medication. In addition, the licensed nurses will be in-serviced on the Administering Medication Policy with emphasis on item #27 that residents may self-administer their own medication only if the attending physician in conjunction with the IDT team, that the resident has the decision-making capability to do so.		6/25/25

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F 554	Continued From page 2 facility does not have a policy or process for the use of the FreeStyle Libre 3 continuous blood glucose monitoring device and had not completed any training or competencies to ensure nursing staff were knowledgeable and had an understanding of how the device worked. In addition she agreed R13's self administration assessment did not identify if R13 was knowledgeable enough to use the Libre 3 independently and did not identify that any guidance was provided. Review of the current, undated, FreeStyle Libre 3 manufacturer instructions, located at, https://www.freestyleprovider.abbott/us-en/patient-training.html?type=fsl3&&msclkid=137e6c7baf1615aea40e0450ecf20f55&utm_source=bing&utm_medium=cpc&utm_campaign=M%20%7C%20BR%20%7C%20FreeStyle%20Libre%203&utm_term=freestyle%20libre%203&utm_content=Libre%203&gclid=137e6c7baf1615aea40e0450ecf20f55&gclsrc=3p.ds&gad_source=7 , identified prior to using the device, patients were to review all the product instructions and complete the interactive tutorials. In addition, the instructions identified there are symbols that may be displayed on the monitor screen to warn when a manual blood glucose level should be completed.	F 554	Director of Nursing and/or designee is responsible for compliance. Audits on self-administration assessment completion, medications left at bedside without self-administration assessment completed and resident compliance to self-administration procedure will begin 2x week for 2 weeks, weekly x 2 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 06/25/2025		
F 605 SS=D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not	F 605			6/25/25

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F 605	Continued From page 3 required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure psychotropic medications had identified target behaviors or symptoms, failed to monitor the target behaviors or symptom, and failed to monitor for adverse effects of the medication for 1 of 4 residents (R4) reviewed for psychotropic medication use. Additionally, the facility failed to have non-pharmacological meaningful interventions that were personalized for target behaviors or symptoms. Findings include: R4's 4/24/25, quarterly Minimum Data Set (MDS)	F 605	R4 medications were reviewed for diagnosis and indications for use. R4 s psychotropic medication had target behavior added to the order, behavior monitoring/look back monitoring activated, and non-pharmacological interventions added. R4 care plan was reviewed and updated and the necessary care plans to address psychotropic medication use was activated, updated with the target behavior and a progress note created if any adverse effects were observed. All current residents who are on psychotropic medications, their medication orders,		

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F 605	Continued From page 4 identified R4's cognition was moderately impaired. She had functional limitations of both upper and lower extremities and required extensive to total assistance with cares. R4 took an antipsychotic and antidepressant medication. The MDS identified diagnoses of neurological condition, left side weakness, heart failure, diabetes mellitus, and seizure disorder. R4's 5/13/25, Order Summary Report identified bupropion HCI ER (Wellbutrin XL) 300 milligrams (mg) every day (QD) an antidepressant medication for mood disorder due to known physiological condition. Quetiapine Fumarate (Seroquel) 300 mg at bedtime (antipsychotic medication) for encephalomalacia due to previous stroke (serious brain injury that causes memory loss, changes in personality and behaviors). Vilazodone HCI 20 mg QD (antidepressant) for mood disorder due to known physiological condition. The orders lacked identification of target behaviors or symptoms the medication was ordered to treat and lacked monitoring of the medication adverse effects. Interview on 5/13/25 at 11:32 a.m., with nursing assistant (NA)-B identified R4 has hallucinated and thought there were raccoons in her room. Staff would reassure her when she thought she saw something and reported to the nurse. Interview on 5/14/25 at 2:00 p.m., with NA-A identified R4 reported seeing things like raccoons and opossums in her room, she heard scratching noises "all the time", and just last night she thought something was crawling on her. She also reportedly had days when she thought she could still get up and walk which she cannot do. When she had hallucinations like that, staff reassured	F 605	target behavior monitoring module and care plans were reviewed and updated as needed. Future residents who are admitted to the facility will have a review of their psychotropic medications, target behavior identified, non-pharmacological interventions initiated and behavior monitoring per facility policy. Licensed nurses and IDT team will be in-serviced on the Behavioral Assessment Monitoring policy with emphasis on item #7, 8 and 9 that directs the team to identify and individualize targeted behavioral approaches and to utilize non-pharmacologic approaches to the extent possible. Social Service Designee is responsible for compliance. Audits on resident target behaviors, non-pharmacological interventions attempted, behavioral monitoring and adverse side effects will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 06/25/2025		

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F 605	Continued From page 5 her and reported to the nurse. R4's 1/24/25, mental health visit provider note identified R4 had a mood disorder NOS (not otherwise specified), anxiety disorder, and unspecified psychosis. R4 was identified to have visual hallucinations about animals being in her bed (opossums). R4 reported she felt like her stroke had really exacerbated her negative mood. R4's 4/29/25, care plan identified psychotropic medication management related to insomnia, depression, and anxiety. The goal was the resident would be free from side effects. The intervention was to consult pharmacist to review medications. R4 refused cares at times related to depression, anxiety, and stroke. The goal was the resident will cooperate with care through the review date. The interventions included allow the resident to make decisions about treatment regime, to provide sense of control, encourage participation, staff to give clear explanation of all care activities prior to occurrence, and/or postpone care and re-approach if R4 continued to resist. The care plan lacked what the target behaviors or symptom were and lacked personalized non-pharmacological interventions and lacked identification of R4's hallucinations or delusional thoughts and what staff were to do when these occurred. Interview on 5/14/25 at 2:36 p.m., with consulting pharmacist identified she would expect target behaviors or symptoms would be identified for psychotropic medication on either the resident's care plan or on the medication administration record. She further identified she would expect that staff would be monitoring those target behaviors or symptoms for effectiveness of the	F 605			

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F 605	Continued From page 6 medication. Interview on 5/14/25 at 3:52 p.m., with assistant director of nursing (ADON) identified she was unsure how the facility was monitoring target behaviors or symptoms if the facility had not identified what those symptoms were. She further revealed she was unsure how the facility was monitoring for side effects of the psychotropic medications. She confirmed there was nothing on the medication administration record or care plan that identified the target behaviors or symptoms for the medication use. She reported corporate had the facility now using a new "library" that had pre-defined problems and intervention to create care plans. With the new program the care plans were now lacking individualized problems and interventions as she was required to choose from the library pick list. Review of the 4/25/25, Psychotropic Medication Use policy identified resident would only receive medications that are clinically indicated to treat specific conditions. A comprehensive assessment should be completed, and nonpharmacological interventions identified to minimize the need for a psychotropic medication. Residents on psychotropic medication should receive a gradual dose reduction unless contraindicated to discontinue the medication. Psychotropic medications are prescribed to treat specific condition or symptom which should be documented in the resident medical record. Psychotropic medications are to be monitored for adverse effects.	F 605			
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641			6/25/25

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NAME OF PROVIDER OR SUPPLIER VALLEY VIEW MANOR HCC			STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152		
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F 641	Continued From page 7 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident status was accurately identified in the Minimum Data Set (MDS) assessment for 1 of 12 sampled residents (R24). Findings include: R24's 5/17/24, Preadmission Screening Results (PAS) identified no level II assessment was needed. The PAS identified that R24 had post-traumatic stress disorder (PTSD), anxiety, and depression. R24's 5/27/24, admission Minimum Data Set (MDS) assessment lacked identification of PTSD. R24's 8/27/24, quarterly and the 10/21/24, significant change MDS identified PTSD diagnosis. R24's 5/14/25, medical diagnosis list identified PTSD, depression, and anxiety. Interview on 5/14/25 at 3:52 p.m., with assistant director of nursing (ADON) identified she would expect the MDS would be coded correctly to reflect the resident's actual condition. She reported R24's admission MDS had been completed by a contracted staff and she now had taken over completing the MDS's at the facility. She confirmed that R24's admission MDS had lacked identification of the PTSD diagnosis. Which would trigger care planning for PTSD to ensure support provided.	F 641	R24 s admission MDS will be modified to include PTSD diagnosis that was missed. R24 s subsequent MDSs were reviewed and updated as needed. All current residents PAS screening, diagnosis and MDSs were reviewed updated as needed. Future residents will have their MDSs coded accurately per RAI manual. The MDS coordinator and social service designee will be in-serviced on the RAI manual section I of the RAI manual chapter 3 page I-7 that physician documented diagnosis in the last 60 days that have a direct relationship to the resident s current functional status, cognitive, mood or behavior is checked by reviewing the medical record for the last 7 days to identify active diagnosis. The MDS coordinator is responsible for compliance. Audits on Section I diagnosis accuracy will begin weekly x 3 weeks, then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 06/25/2025		

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F 641	Continued From page 8	F 641			
F 656 SS=D	Review of the Resident Assessment Instrument (RAI) manual 3.0 identified residents MDS submissions must be accurate during the look back period and in accordance with standards of clinical practice and documentation. Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and	F 656			6/25/25

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F 656	Continued From page 9 desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan that addressed anticoagulant (prevents and breaks down blood clots) therapy with safety precautions for 1 of 1 (R25) resident reviewed for care plan. Findings include: R25's 3/06/25, Significant change Minimum Data Set (MDS) identified R25 was admitted February 2025. R25 had a diagnosis of atrial fibrillation (irregular heart rhythm) and hip fracture. R25 was moderately cognitively impaired and had taken anticoagulants on a routine basis. R25's current, undated Order Summary Report identified R25 was to receive Eliquis (anticoagulant used to prevent blood clots) 2.5 milligrams (mg) twice a day for atrial fibrillation. The order identified the medication was to start on 8/19/24.	F 656	R25 had an Anti-coagulation therapy care plan with the appropriate safety preventions activated on 6/6/25. There were no ill effects experienced by R25 with this deficient practice. Current residents who are on anticoagulation therapy will have their orders reviewed and care plans updated as needed. Future residents who admit will have the appropriate comprehensive care plan items initiated by the facility policy. The facility IDT team will be in-serviced on the Comprehensive Care Plan Policy with focus on item #7 that the comprehensive care plan must include measurable objectives and timeframes and include any specialized services that are needed to build on residents strengths and reflect currently recognized standards of practice for problem areas and conditions. The Director of Nursing is responsible for compliance.		

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F 656	Continued From page 10 R25's current, undated care plan lacked individualized documentation of pharmacological and non-pharmacological interventions for R25, as well as, side effects and/or adverse effects of the medication use. Interview on 5/14/25 at 9:40 a.m., with registered nurse (RN)-A identified the risk of bleeding was an indicator of anticoagulant use. RN-A accessed R25's chart on Point Click Care (PCC), an online medical record, identified R25's care plan lacked evidence of monitoring for anticoagulation therapy. Interview on 5/14/25 at 9:53 a.m., with RN-B identified R25 was administered Eliquis and was to be monitored for symptoms such as, dark color stools, bruising, abnormal bleeding or severe paleness of the skin. RN-B had voiced agreement appropriate interventions should be reflected in R25's care plan. Interview on 5/14/25 4:06 p.m., with assistant director of nursing (ADON) identified R25's care plan should reflect interventions, including drug specific side effects for use of anticoagulant medications. Review of facility current, undated Care Plans, Comprehensive Person-Centered policy indicated care plans was to include services related to the physical, mental and psychosocial well-being of the resident, measurable objectives and timeframes, and desired outcomes. The comprehensive care plan was to include ongoing assessments, revision of services, and interventions related to areas of concern.	F 656	Audits on comprehensive care plan completion date, CAA area care plans initiated per resident diagnosis and medications will begin weekly x 4 weeks, then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administration will take audit results to QAPI for review and recommendation. Compliance: 06/25/2025		

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F 657	Continued From page 12 assessment identified R8's cognition was intact. R8 required extensive assistance by one staff for transfers, toileting, and bed mobility. R8 took insulin daily and a diuretic (medication to remove fluid excess from the body). R8's 5/14/25, diagnosis list identified Alzheimer's disease, congestive heart failure, pain in right toes, pain in left ankle and foot, osteoarthritis, and diabetes mellitus. R8's 4/30/25, emergency department (ED) provider note identified R8 had presented to the ED for evaluation of increased weakness and falls. Assessment noted bruising with some swelling and tenderness of the left lower leg and ankle area. Some bruising was noted as being present on the right lower leg but without any tenderness. X-ray of left ankle revealed a fractured ankle and the ankle was splinted. The note indicated R8 would benefit from orthopedic follow-up to discuss whether surgical options would be helpful given she is ambulatory at baseline (prior to the fall). R8 was discharged back to the facility. Observation on 5/13/25 at 11:10 a.m., 2 staff exiting R8's room one with the Hoyer mechanical lift (full body lift) and 1 staff pushing R8 in her wheelchair. Interview on 5/13/25 at 11:47 a.m., with nursing assistant (NA)-B identified R8 used to transfer with one staff assist but since she fractured her ankle, she now required use of a total body mechanical life (Hoyer) with assist of 2 staff as she was non-weight bearing. Interview on 5/13/25 at 11:47 a.m., with nursing assistant (NA)-B identified R8 used to transfer	F 657	Current residents who have significant changes and/or quarterly reviews, their care plans will be reviewed by the IDT team and updated as needed. Future residents care plans will be reviewed quarterly, significant changes and as needed per facility policy. Licensed nurses and the IDT team was in-serviced on the Facility Resident Care Conference/Care Plan Review policy which explains the purpose of the care conference is to develop a plan of care and to ensure that the resident goals and preferences were discussed and established and to aid in better resident care outcomes for our long-term, and safe discharges to the community for our short-term residents. In addition, the IDT team was in-serviced on timing of care plan reviews which should occur upon admission (baseline), quarterly, significant change, annually and as needed. The Social Service designee is responsible for compliance. Audits on the timeliness of the initial care, quarterly care conference, significant change care conference and care plan interventions updates will begin weekly x 4 weeks, then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administration will take audit results to QAPI for review and recommendation. Compliance: 06/25/2025		

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F 657	Continued From page 13 with 1 staff assist but since she fractured her ankle, she required a Hoyer lift with 2 staff as she was non-weight bearing. Interview on 5/14/25 at 2:00 p.m., with NA-A identified R8 was not previously transferred using a Hoyer mechanical lift with 2 staff. R8 used to transfer with 1 staff and ambulate with 1 staff prior to her fall and fractured ankle. R8's undated, care plan identified R8 required extensive assist of 1 staff for toileting, bathing, bed mobility, dressing, and transferring. R8 required extensive assist of 1 staff and a front wheeled walker for ambulation. The care plan lacked revision that R8 now required total assist by 2 staff using a Hoyer mechanical lift for transfers as R8 was non-weight bearing on her left leg after her fall. Interview on 5/14/25 at 3:52 p.m., with assistant director of nursing (ADON) confirmed R8's care plan had not been updated to reflect her current care needs following her fractured ankle. She reported R8 currently required a Hoyer mechanical lift for all transfers with 2 staff assist. Review of 4/22/25, Care Plans, Comprehensive Person-Centered policy identified that resident assessments were ongoing and care plans are revised as the resident's condition changes.	F 657			
F 726 SS=F	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure	F 726			6/25/25

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F 726	Continued From page 14 resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff were competent to use a continuous glucose monitoring device (FreeStyle Libre 3) for 1 of 1 resident (R)13 who had a diagnosis of diabetes. Findings include: R13's admission Minimum Data Set (MDS) assessment identified her cognition was intact, she required assistance from staff to complete	F 726	R13 had a new self-administration of medications completed and the MD was contacted for medication review. R13 MD orders will be processed and implemented. R13 care plan will be reviewed and updated. Currently, there are no other residents who have continuous glucose monitoring machines. Future residents who are admitted to the facility and require glucose monitoring will have their blood glucose monitored via		

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F 726	Continued From page 15 activities of daily living (ADL)'s, and had diagnosis of diabetes, heart failure, respiratory failure, bi-polar disorder, borderline personality disorder, and depression. R13's May 2025, administration record identified she was to have her blood glucose level monitored and recorded three times a day before meals. R13 was to be administered 40 units of insulin aspart protamine and insulin aspart (a combination of fast acting and intermediate acting insulin to keep blood sugar levels under control) subcutaneous two times a day at 8:00 a.m., and 4:00 p.m. In addition, R13 was to be administered a correction dose based on her blood sugar levels at the time of administration. R13's 4/30/25 through 5/13/25, documented blood glucose levels identified her blood sugars ranged from 70 Milligrams per deciliter (mg/dl)-403mg/dl. Target blood glucose levels for people with diabetes is 80-130mg/dl. Interview on 5/14/25 at 8:02 a.m., with registered nurse (RN)-B identified she was familiar with these types of devices similar to what R13 used for blood glucose monitoring because she had used them at other facilities. She revealed she had not received training on the device since working at this facility and had not completed a competency. She identified she did not know where the manufacturer directions were but thought they were on the charge nurse med cart or in the medication room. Interview on 5/14/25 at 8:07 a.m., with registered nurse (RN)-A identified he was the charge nurse and had never worked with a continuous blood glucose monitoring device. He was not aware of	F 726	fingerstick per facility policy. Facility licensed nurses will be in-serviced on the Diabetes Care Plan with emphasis on monitoring and follow up section of the policy that the physician will order the appropriate lab test i.e., finder sticks or A1C levels and will adjust treatments based on these results. In addition, licensed nurses will have in-service education and competency on Obtaining Fingerstick glucose levels. The Director of Nursing is responsible for compliance. Audits on glucose monitoring orders and fingerstick procedure will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administration will take audit results to QAPI for review and recommendation. Compliance: 06/25/2025		

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F 726	Continued From page 16 what type of device R13 used and was not aware if the facility had manufacturer directions or where they would be located if they did. He identified they may be on the other medication cart with R13's other medications. He revealed he had not been trained how to use the device and had not completed a competency. Interview on 5/14/25 at 1:04 p.m., with the assistant director of nursing (ADON) identified the facility does not have a policy or process for the use of the FreeStyle Libre 3 continuous blood glucose monitoring device and had not completed any training or competencies to ensure nursing staff were knowledgeable and had an understanding of how the device worked. Interview on 5/14/25 at 8:15 a.m., with R13 identified she told the nurse what her blood sugar was. If R13's blood sugar was low they [nurses] gave R13 orange juice or a snack. R13 was not aware of any time that she would need to do a manual blood sugar check and was not familiar with how the alarms worked on the device. Interview on 5/14/25 at 4:11 p.m., with the administrator identified she would expect the facility would ensure nursing staff were trained and competent in the use of any medical equipment used for the treatment and medication therapy of residents who reside at the facility. Review of the FreeStyle Libre 3 manufacturer directions identified that prior to using the device, review all the product instructions and complete the interactive tutorial at www.FreeStyleLibre.com. In addition, the instruction identified there are symbols that may be displayed on the monitor screen to warn when			F 726			

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F 726	Continued From page 17	F 726			
F 802 SS=F	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b) (2)(ii). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure dietary staff had appropriate training with competencies to carry out the function of monitoring the dish machine temperatures to ensure appropriate sanitation occurred. Findings include: Observation and interview on 5/13/25 at 9:30 a.m., with dietary aide (DA)-A who ran a load of dishes through the dish machine. The gauge	F 802	ECOLAB was contacted for additional training materials and/or potential onsite demonstration of the facility dishwasher machine by the technician. Dietary employees will have competency performed for the dishwasher process and a post test will be administered. There were no ill effects experienced on residents with this deficient practice. Future dietary employees will have general orientation, introduction to dietary department modules via Relias and the		6/25/25

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F 802	Continued From page 18 located on the right side was at 170 degrees and did not move. The gauge, located on the left side moved during the wash and rinse cycle showing the wash cycle was to be 160 degrees and the rinse cycle was 180 degrees. DA-A reported she observed and documented temperatures once a shift. She reported the left gauge was the wash cycle, and the right gauge was the rinse cycle. When DA-A was asked if the temperature needed to reach a certain temperature, she replied there was no special temperature it had to be. Interview and observation on 5/13/25 at 10:11 a.m., with maintenance director identified one gauge read both the wash and rinse temperature. The maintenance director accompanied the surveyor to the dish machine and ran a cycle confirming that the left gauge read both the wash and rinse temperatures. He reported he did not think that the right gauge was even working. Review of the Dish Machine Temperature logs for March, April, May of 2025, identified the logs identified the rinse temperature fell below a safe sanitizing level of 180 degrees Fahrenheit (F) during the following meal services in: 1) March 2025: Breakfast 18 of 31 days, Dinner 4 of 31 days, Supper 4 of 31 days. Staff failed to document any temperature level for 11 of 31 days. 2) April 2025: Breakfast 13 of 30 days. There was no documentation sanitation had been achieved for 4 of 30 days during the breakfast meal service. During the dinner meal, 6 of 30 days fell below 180 degrees F. Further review of the dinner meal service identified 6 of the 30 days also had no documentation to support staff had monitored rinse temperatures. Supper meal service fell below safe temperatures 2 of 30 days.	F 802	dietary manager will orientate employees to the department per facility policy. The Certified Dietary Manager will be in-serviced on the Certified Dietary Manager job description with emphasis on the description that the primary purpose of this position is to plan, organize, develop and direct the operations of the food and nutrition services department in accordance with current federal, state and local standards, guidelines and regulations and as directed by the Administrator. The Certified Dietary Manager is responsible for compliance. Audits on dietary competency completion and dish machine operation and post-test will begin weekly x 2 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administration will take audit results to QAPI for review and recommendation. Compliance: 06/25/2025		

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F 802	Continued From page 19 Staff failed to document 12 supper meal service rinse temperatures for the 30 days in April. 3) May 2025: Breakfast 8 of 13 days fell below 180 degrees F. Dinner 1 of 12 days fell below, with the Supper meal service falling below 2 of 12 days reviewed with 1 of those 12 days having no documentation to support staff had monitored temperatures. On the form, it was noted if the rinse temperature fell below 180 degrees, F, staff were to contact the dietary manager. Interview on 5/13/25 at 10:16 a.m., with dietary manager identified staff were to contact her or the maintenance director if the wash or rinse temperature was not at the correct temperature. She reported staff were to use the gauge on the left side for monitoring the wash and rinse cycles and staff had been trained on that but did not always follow directions. She confirmed monitoring the wash and rinse cycles was a problem and she reviewed the logs to monitor for a pattern. She confirmed several rinse temperatures were under 180 degrees. Additional interview on 5/13/25 at 1:40 p.m., confirmed she had not addressed the low rinse temperatures with any staff previously. She reported staff completed training on Relias, the facility online training system. Then before staff start in the kitchen, she trained staff on the cleaning dishes machine policy. Review of DA-A, DA-B, and cook-A training and competencies identified: 1) DA-A, had no competency documentation related to monitoring the dish machine wash and rinse cycle temperatures to ensure appropriate sanitation occurred. There was no documentation the dietary policies had been read or reviewed.	F 802			

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F 802	Continued From page 20 2) DA-B, had no documentation of competencies or the policies had been read and reviewed. 3) Cook-A, had no competency documentation related to monitoring the dish machine wash and rinse cycle temperatures to ensure appropriate sanitation occurred. She signed on 9/11/24, she read the dietary policies. Interview on 5/13/25 at 1:40 p.m., with dietary manager revealed DA-B had no competencies related to her job functions, she only had received initial training which included an overview of food service. Interview on 5/13/25 at 2:58 p.m., with maintenance director identified both gauges were working on the dish machine. He confirmed the Ecolab data plate located on the dish machine identified minimum temperature for wash was 150 and rinse was 180. The right gauge did not move unless the machine was shut off, and the left gauge bounce back and forth for the wash and rinse cycle. He confirmed if the dish machine did not reach those temperatures staff were to contact the dietary manager or him to address. Interview on 5/14/25 at 9:24 a.m., with dietician identified sometimes the dish machine needed to run a couple cycles to get up to temperature. If the dish machine was not getting to recommended temperature for the wash and rinse cycle, then the dietary manager needed to be notified, and a maintenance request needed to be made. He would expect staff would be knowledgeable about how to read the temperature gauges, daily monitoring was being completed, and staff would report any concerns of the temperatures not reaching recommended temperature for wash or rinse cycles.	F 802			

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F 802	Continued From page 21 Interview on 5/14/25 at 12:54 p.m., with dietary manager identified maintenance confirmed both gauges are working, and the maintenance director labeled the gauges for monitoring wash and rinse temperatures. She revealed that had not been how she was trained by Ecolab, but it now made sense. Review of the undated, ECOLAB XL HT (hot water sanitizing, electrically heated dish machine) Operation Manual identified the wash temperature for 150 degrees minimum in the hot water sanitizing mode. The rinse temperature at 180 degrees minimum in the hot water sanitizing mode. A diagram in the manual identifies on the machine the left gauge as the thermometer rinse temperature and the gauge on the right as the thermometer wash temperature. Review of the undated, Dietary Aide Training list identified staff were to wash dishes and chart dishwasher temperatures. Review of the undated, Cleaning Dishes/Dish Machine policy identified prior to using the dish machine staff were to verify proper temperatures and machine function. Staff were to check the dish machine gauges throughout the cycle to assure proper temperatures for sanitation. The policy identified dish machine wash temperature should reach a minimum of 150 and the rise cycle to reach minimum of 180 degrees. Staff were to monitor temperatures and document to assure proper sanitizing of the dishes. Staff were trained to report any problems with the dish machine to the dietary manager. The dietary manager was to take immediate action to assure proper sanitation of the dishes.			F 802			

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F 838 SS=F	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the	F 838			6/25/25

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F 838	Continued From page 23 facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a) (1). § 483.71(b) In conducting the facility assessment, the facility must ensure: § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an	F 838			

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F 838	Continued From page 24 administrator, and the director of nursing; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable. (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members. §483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3). §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care.	F 838			

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F 838	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to develop and implement 1 of 1 facility assessment to ensure staff were trained and deemed competent for blood glucose monitoring and device usage. In addition, the facility failed to ensure 1 of 1 dietary aides (DA-A) was trained to ensure appropriate sanitation occurred in the dishwashing machine. Findings include: BLOOD GLUCOSE MONITORING Observation and interview on 5/14/25 at 8:15 a.m., with R13 identified she had a sensor on the back of her arm and a hand held meter. She placed the meter near the sensor and it recorded her blood glucose level. She identified the nurse would come in and ask her what her blood sugar is and she would tell them. "If my blood sugar is low they give me orange juice or a snack". R13 was not aware of any time that she would need to do a manual blood sugar check and was not familiar with how the alarms worked on the device. Review of R13's Self Administration of Medications assessment did not identify R13 had been given any guidance or assessed to ensure she was knowledgeable on how to use the monitor or when she would need to complete a manual blood glucose check to ensure accuracy. Review of the FreeStyle Libre 3 manufacturer instructions, located at https://www.freestyleprovider.abbott/us-en/patient-training.html?type=fsl3&&msclkid=137e6c7baf1615aea40e0450ecf20f55&utm_source=bing&utm_			F 838	R13 had a new self-administration of medications completed and the MD was contacted for medication review. R13 MD orders will be processed and implemented. R13 care plan will be reviewed and updated. Currently, there are no other residents who have continuous glucose monitoring machines. Future residents who are admitted to the facility and require glucose monitoring will have their blood glucose monitored via fingerstick per facility policy. ECOLAB was contacted for additional training and/or a return demonstration of the facility dishwasher machine. Competency will be performed with all dietary department employees by the dietary manager and a post-test will be administered. There were no ill effects experienced to residents with this deficient practice. Future dietary employees will have general orientation, introduction to dietary department modules via Relias and the dietary manager will orientate employees to the department per facility policy. The Facility Assessment was reviewed and there were no changes warranted. The Administrator, DON and ADON will be in-serviced on the Facility Assessment Policy with emphasis on item #4 that the facility assessment includes a detailed review of the services provided and if there are any changes to personnel or training, the Facility Assessment must be updated. The Executive Director will be responsible		

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F 838	Continued From page 26 medium=cpc&utm_campaign=M%20%7C%20BR%20%7C%20FreeStyle%20Libre%203&utm_term=freestyle%20libre%203&utm_content=Libre%203&gclid=137e6c7baf1615aea40e0450ecf20f55&gclsrc=3p.ds&gad_source=7, identified prior to using the device, patients were to review all the product instructions and complete the interactive tutorials. In addition, the instructions identified there are symbols that may be displayed on the monitor screen to warn when a manual blood glucose level should be completed. Interview on 5/14/25 at 8:02 a.m., with registered nurse (RN)-B identified she was familiar with these types of devices like R13 used for blood glucose monitoring because she had used them at other facilities. She revealed she had not received training on the device since working at this facility and had not completed a competency. She identified she did not know where the manufacturer directions were but thought they were on the charge nurse med cart or in the medication room. Interview on 5/14/25 at 8:07 a.m., with registered nurse (RN)-A identified he was the charge nurse and had never worked with a continuous blood glucose monitoring device. He was not aware of what type of device R13 used and was not aware if the facility had manufacturer directions or where they would be located if they did. He identified they may be on the other medication cart with R13's other medications. He revealed he had not been trained how to use the device and had not completed a competency. Interview on 5/14/25 at 1:04 p.m., with the assistant director of nursing (ADON) identified the facility does not have a policy or process for the	F 838	for compliance. Audits on dietary and nurse in-service education as listed in F802 and F726 will be conducted per the listed frequency. Audit results will be reviewed by the Administrator and the Administration will take audit results to QAPI for review and recommendation. Compliance: 06/25/2025		

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F 838	Continued From page 27 use of the Freestyle Libre 3 continuous blood glucose monitoring device and had not completed any training or competencies to ensure nursing staff were knowledgeable and had an understanding of how the device worked. Interview on 5/14/25 at 4:11 p.m., with the administrator identified she would expect the facility would ensure nursing staff were trained and competent in the use of any medical equipment used for the treatment and medication therapy of residents who reside at the facility. Review of the 5/12/25, Facility Assessment identified the facility was to provide for services to residents in relation to diabetic management. All nursing staff were required to complete general orientation and competencies upon hire. Ongoing training/education opportunities were to be completed annually. Competency testing was to be done on an annual basis. Training topics were to include identification of resident changes in condition, including how to identify medical issues appropriately, how to determine if symptoms represent problems in need of intervention, how to identify when medical interventions are causing rather than helping relieve suffering and improve quality of life and include medication administration and resident assessment and exam and providing specialized care for diabetic glucose testing. DIETARY Observation and interview on 5/13/25 at 9:30 a.m., with dietary aide (DA)-A who ran a load of dishes through the dish machine. The gauge located on the right side was at 170 degrees and did not move. The gauge, located on the left side moved during the wash and rinse cycle showing	F 838			

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F 838	Continued From page 28 the wash cycle was to be 160 degrees and the rinse cycle was 180 degrees. DA-A reported she observed and documented temperatures once a shift. She reported the left gauge was the wash cycle, and the right gauge was the rinse cycle. When DA-A was asked if the temperature needed to reach a certain temperature, she replied there was no special temperature it had to be. Interview and observation on 5/13/25 at 10:11 a.m., with maintenance director identified one gauge read both the wash and rinse temperature. The maintenance director accompanied the surveyor to the dish machine and ran a cycle confirming that the left gauge read both the wash and rinse temperatures. He reported he did not think that the right gauge was even working. Review of the Dish Machine Temperature logs for March, April, May of 2025, identified the logs identified the rinse temperature fell below a safe sanitizing level of 180 degrees Fahrenheit (F) during the following meal services in: 1) March 2025: Breakfast 18 of 31 days, Dinner 4 of 31 days, Supper 4 of 31 days. Staff failed to document any temperature level for 11 of 31 days. 2) April 2025: Breakfast 13 of 30 days. There was no documentation sanitation had been achieved for 4 of 30 days during the breakfast meal service. During the dinner meal, 6 of 30 days fell below 180 degrees F. Further review of the dinner meal service identified 6 of the 30 days also had no documentation to support staff had monitored rinse temperatures. Supper meal service fell below safe temperatures 2 of 30 days. Staff failed to document 12 supper meal service rinse temperatures for the 30 days in April. 3) May 2025: Breakfast 8 of 13 days fell below	F 838			

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F 838	Continued From page 29 180 degrees F. Dinner 1 of 12 days fell below, with the Supper meal service falling below 2 of 12 days reviewed with 1 of those 12 days having no documentation to support staff had monitored temperatures. On the form, it was noted if the rinse temperature fell below 180 degrees, F, staff were to contact the dietary manager. Interview on 5/13/25 at 10:16 a.m., with dietary manager identified staff were to contact her or the maintenance director if the wash or rinse temperature was not at the correct temperature. She reported staff were to use the gauge on the left side for monitoring the wash and rinse cycles and staff had been trained on that but did not always follow directions. She confirmed monitoring the wash and rinse cycles was a problem and she reviewed the logs to monitor for a pattern. She confirmed several rinse temperatures were under 180 degrees. Additional interview on 5/13/25 at 1:40 p.m., confirmed she had not addressed the low rinse temperatures with any staff previously. She reported staff completed training on Relias, the facility online training system. Then before staff start in the kitchen, she trained staff on the cleaning dishes machine policy. Review of DA-A, DA-B, and cook-A training and competencies identified: 1) DA-A, had no competency documentation related to monitoring the dish machine wash and rinse cycle temperatures to ensure appropriate sanitation occurred. There was no documentation the dietary policies had been read or reviewed. 2) DA-B, had no documentation of competencies or the policies had been read and reviewed. 3) Cook-A, had no competency documentation	F 838			

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F 838	Continued From page 30 related to monitoring the dish machine wash and rinse cycle temperatures to ensure appropriate sanitation occurred. She signed on 9/11/24, she read the dietary policies. Interview on 5/13/25 at 1:40 p.m., with dietary manager revealed DA-B had no competencies related to her job functions, she only had received initial training which included an overview of food service. Interview on 5/13/25 at 2:58 p.m., with maintenance director identified both gauges were working on the dish machine. He confirmed the Ecolab data plate located on the dish machine identified minimum temperature for wash was 150 and rinse was 180. The right gauge did not move unless the machine was shut off, and the left gauge bounce back and forth for the wash and rinse cycle. He confirmed if the dish machine did not reach those temperatures staff were to contact the dietary manager or him to address. Interview on 5/14/25 at 9:24 a.m., with dietician identified sometimes the dish machine needed to run a couple cycles to get up to temperature. If the dish machine was not getting to recommended temperature for the wash and rinse cycle, then the dietary manager needed to be notified, and a maintenance request needed to be made. He would expect staff would be knowledgeable about how to read the temperature gauges, daily monitoring was being completed, and staff would report any concerns of the temperatures not reaching recommended temperature for wash or rinse cycles. Interview on 5/14/25 at 12:54 p.m., with dietary manager identified maintenance confirmed both	F 838			

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F 838	Continued From page 31 gauges are working, and the maintenance director labeled the gauges for monitoring wash and rinse temperatures. She revealed that had not been how she was trained by Ecolab, but it now made sense. Review of the undated, ECOLAB XL HT (hot water sanitizing, electrically heated dish machine) Operation Manual identified the wash temperature for 150 degrees minimum in the hot water sanitizing mode. The rinse temperature at 180 degrees minimum in the hot water sanitizing mode. A diagram in the manual identifies on the machine the left gauge as the thermometer rinse temperature and the gauge on the right as the thermometer wash temperature. Review of the undated, Dietary Aide Training list identified staff were to wash dishes and chart dishwasher temperatures. Review of the undated, Cleaning Dishes/Dish Machine policy identified prior to using the dish machine staff were to verify proper temperatures and machine function. Staff were to check the dish machine gauges throughout the cycle to assure proper temperatures for sanitation. The policy identified dish machine wash temperature should reach a minimum of 150 and the rise cycle to reach minimum of 180 degrees. Staff were to monitor temperatures and document to assure proper sanitizing of the dishes. Staff were trained to report any problems with the dish machine to the dietary manager. The dietary manager was to take immediate action to assure proper sanitation of the dishes. Review of the 5/12/25, Facility Assessment identified staff training/education and competencies from other departments other than	F 838			

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F 838	Continued From page 32 nursing was completed initially upon hire and annually. Annual online Relias training was to be completed by all staff. The Relias training included infection control as part of the facilities infection prevention training that covered written standards, policies, and procedures. The facility assessment further identified for Food and Nutrition Services, the facility would employ staff with appropriate competencies and skill sets to caring out the functions of the nutritional services. Review of the 5/12/25, Facility Assessment identified staff training/education and competencies from other departments other than nursing was completed initially upon hire and annually. Annual online Relias training was to be completed by all staff. The Relias training included infection control as part of the facilities infection prevention training that covered written standards, policies, and procedures. The facility assessment further identified for Food and Nutrition Services, the facility would employ staff with appropriate competencies and skill sets to caring out the functions of the nutritional services.	F 838			
F 849 SS=D	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services	F 849			6/25/25

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F 849	Continued From page 33 when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes	F 849			

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F 849	Continued From page 34 responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.	F 849			

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F 849	Continued From page 35 (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient.	F 849			

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F 849	Continued From page 36 (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to have an integrated care plan to coordinate and delineate what services hospice was to provide and what services the facility was to provide, to ensure oversight and services would be provided for 1 of 1 resident (R11) reviewed for hospice care. Findings include: R11's 3/9/25, annual Minimum Data Set (MDS)	F 849	R11 s will have a care plan focus initiated, comfort for end-of-life interventions will be activated and hospice interventions/visit schedule will be added to the intervention section. All current residents who are receiving hospice services their care plans will be reviewed and/or updated as needed. Future residents who elect hospice services will have their orders reviewed and the care plan initiated by facility policy.		

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F 849	Continued From page 37 assessment identified R11 was dependent on staff for all cares, he received hospice services. R11's undated facility care plan identified activities of daily living (ADL) deficit related to dementia and muscle/skeletal impairment. R11 was dependent on staff for care needs. The nutrition focus area identified R11 had nutritional problem related to diagnosis of alcohol dependency, anxiety, hepatitis C, dementia, epilepsy, hypertension, insomnia, depression, seizures, psychosis, and hospice status. There was no other mention of hospice as a whole, nor was there mention of what services the facility was to provide, or what services hospice was to provide mentioned on R11's care plan. R11's direct care staff Kardex (care plan) that staff review identified bathing, R11 required 2 staff assist. There was no mention of hospice on the Kardex and no mention staff were to assist hospice once a week with ensuring R11 had a bath. R11's 4/20/25, hospice care plan identified services required for R11 were providing a home health aide, massage therapy, social services, nursing, and spiritual care visits. R11 required 2 persons for transfer with a mechanical lift. Hospice would provide a tub bath or shower with facility staff assistance. If there was no facility staff assistance, the hospice aide would complete a bed bath weekly. Massage therapy was to be provided to reduce muscle tension. The interdisciplinary team would review and update R11's care plan and family's understanding as R11's condition requires, but no less than every 15 days. R11's hospice diagnosis was Alcohol dependence with alcohol-inducing persisting	F 849	The DON, ADON and Social Service designee will be in-serviced on the Hospice Program Policy and Procedure with emphasis on item #10 the responsibilities of the facility to meet resident s personal care and item #12 the facility will collaborate with hospice to coordinate care, ensure coordinated care plans and hospice will provide facility staff schedule/frequency of hospice staff visits. Director of Nursing and/or designee is responsible for compliance. Audits on hospice care plan, visit schedule and facility hospice care plan initiation will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and taken to QAPI for review and recommendation. Compliance: 06/25/2025		

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F 849	Continued From page 38 dementia. Interview on 5/13/25 at 1:52 p.m., with assistant director of nursing (ADON) identified the facility switched care plan libraries within point click care (PCC) (the facilities electronic medical record program). The new care plan library did not allow the facility to personalize the care plan like they had done in the past. She confirmed R11 had no mention of hospice on the facility care plan. Further interview on 5/14/25 at 3:52 p.m., with ADON identified the facility had a binder located at the nurse's station with the phone number to contact hospice if needed. Hospice staff would typically call prior to coming to the facility. She felt the hospice care was available to direct care staff however, the hospice binder at the desk "could be beefed" up and include a copy of the hospice care plan. She confirmed the facility care plan should identify hospice but did not feel it necessary to include when staff should update the provider, or hospice as she felt the facility communicated with hospice via phone calls or in person and acknowledged occasionally there had been laps in communication and that could be improved upon. The ADON agreed hospice was not mentioned on the facility's care plan nor had it delineated who was to provide what services and or note how the facility would ensure those services would be provided if for some reason hospice was unable to be at the facility. Interview on 5/14/25 at 2:00 p.m., with nursing assistant (NA)-A identified R11 received two baths a week, one from the facility and one from the hospice provider. The hospice provider also did "special things" with R11 like provide a massage each week.	F 849			

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F 849	Continued From page 39 Interview of 5/14/25 at 2:12 p.m., with hospice provider identified they faxed the hospice care plan to the facility to communicate what hospice was providing for the resident. Typically, hospice left an orange folder or binder with the resident's hospice information however, "We have learned sometimes we place the information into the binder and the facility would remove that information". She was unsure what the facility did with the information. Review of the undated, hospice policy identified hospice responsibility was to determine an appropriate plan of care, address the changing level of services needed and provide medical direction for nursing management of the terminal illness. The facility was responsible for meeting the resident's personal care. The facility would coordinate with hospice, and the resident's representative to ensure the care provided was appropriately based on the residents' individual needs. The facility would notify hospice with a significant change in condition, any clinical complications, a need to transfer out of the facility, and the resident's death. The facility was to coordinate care plans for residents receiving hospice services. Review of the 2013, Hospice Agreement identified a plan of care and individualized written care plan would be established, maintained, reviewed, and modified as needed by the interdisciplinary group. Hospice and the facility will jointly develop and agree upon a coordinated plan of care.	F 849			
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880			6/25/25

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F 880	Continued From page 40 §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 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 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,	F 880			

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F 880	Continued From page 41 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. 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 interview and document review, the facility failed to ensure 1 of 5 staff (housekeeping aide (HK)-A) was appropriately given a second tuberculosis test within 1-2 weeks after the first step was completed upon hire. Review of the current, undated Regulations for Tuberculosis Control in Minnesota Health Care Settings, located at https://www.health.state.mn.us/diseases/tb/rules/tbregmanual.pdf for Tuberculosis Control in Minnesota Health Care Settings, identified	F 880	Housekeeper A TB screening tool was completed, and immunization was given on 5/17/25. Housekeeper A 2nd test was completed on 5/26/25. All current employees TB screening tools and tests were reviewed and updated as needed. There were no ill effects experienced for this deficient practice. Future staff that are hired will have the first TB screening and test performed before hiring. Human Resources, DON and ADON were in-serviced on the TB Employee		

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F 880	Continued From page 42 baseline TB screening is required for all healthcare workers (HCW). Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA.before hire. The second TST may be performed after the health care worker (HCW) starts working with patients. An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Review of employee health file for HK-A, identified HK-A was hired on 4/08/25 and completed a baseline TB symptom screen. HK-A's 4/08/25, Baseline TB Screening for HealthCare Workers (HCW) form indicated, HK-A had received both first and second TST tests on 4/08/25 at 8:20 a.m., and again at 9:30 a.m., which were read on 4/10/25 at 11:00 a.m., and aghain at 2:30 p.m., and were negative. The form indicated if the results of the first test were negative, the second TST series was to be completed in one to three weeks. Review of the current, undated Centers for Disease Control (CDC) Clinical Testing Guidance for Tuberculosis: Tuberculin Skin Test, located at https://www.cdc.gov/tb/hcp/testing-diagnosis/tuberculin-skin-test.html, identified if the first TB skin	F 880	Screening Policy with emphasis on items #1 and #2 which indicate that an employee must be screened and after screening, if no documented verification, an initial skin test must be performed. The Director of Nursing is responsible for compliance. Audits on employee screening tools and TB skin testing completion will begin weekly x 2 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and taken to QAPI for review and recommendation. Compliance: 06/25/2025		

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F 880	Continued From page 43 test result is negative, a second TB skin test should be done 1 to 3 weeks later. If the second TB skin test result is positive, it is probably a boosted reaction. Based on this second test result, the person should be classified as previously infected. This would not be considered a skin test conversion or a new TB infection. However, the patient is a candidate for treatment for latent TB infection. If the second skin test result is negative, the baseline result is negative, and the person would be classified as uninfected. Interview on 5/14/25 at 1:09 p.m., HK-A stated she had received the first TST once hired. HK-A was not made aware a second TST was to be completed. Interview on 5/14/25 at 4:01 p.m., with ADON would expect new hires to complete all TB screening and testing, per facility policy. The ADON identified HK-A's TB form was filled out incorrectly and the employee did not recieve both TB series the same day. The ADON had no documentation to support HK-A had received a second TB test to complete the series and agreed this should be documented as completed. Review of May 2024 Tuberculosis, Employee Screening policy indicated the facility was to screen and test all employees for active TB prior to employment.	F 880			
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 881			6/25/25

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F 881	Continued From page 44 a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a review of antibiotic therapy between 48-72 hours to ensure appropriateness of the continued use of an antibiotic for 1 of 3 (R21) sampled residents. Findings include: Review of the current, undated, Centers for Disease Control (CDC): The Core Elements of Antibiotic Stewardship for Nursing Homes, Appendix A: Policy and Practice Actions to Improve Antibiotic Use, located at https://www.cdc.gov/antibiotic-use/core-elements/pdfs/core-elements-antibiotic-stewardship-appendix-a-508.pdf, identified facilities should evaluate the clinical signs and symptoms when a resident is first suspected of having an infection. Once the resident is placed on an antibiotic, they should be comprehensively reviewed within 48-72 hours after starting the medication to ensure they have been prescribed an effective medication. This is accomplished by reviewing the resident current symptoms and any laboratory results to identify medication effectiveness. The CDC identifies this process as an "antibiotic time-out." Review of the infection control logs from December 2024 through May 2025 identified the following areas of documentation: resident name, admit date, room number/unit, infection onset, type of infection, signs and symptoms, status of	F 881	R21 antibiotic therapy ended 2/11/2025. The MD will be notified that a 72-hr review of antibiotic therapy was not completed. The MDs response will be recorded in the resident record. All residents from survey exit until present, their charts for 72-hr antibiotic stewardship assessments were reviewed and updated as needed. Future residents who begin antibiotic therapy, a 72-hr antibiotic time out assessment will be completed and results relayed to MD if needed. Licensed nurses were in-serviced on the Antibiotic Stewardship Procedure with emphasis on page 3 that indicates at 72 hours after antibiotic initiation or first dose in the facility, each resident will be reassessed for consideration of antibiotic need, duration, selection, and de-escalation potential. At this time, laboratory testing results, response to therapy, resident condition, and facility needs (e.g., outbreak situation) will be considered. Completion of an antibiotic time-out must be recorded in the resident record. The Director of Nursing is responsible for compliance. Audits on antibiotic infection care creation, ABT antibiotic stewardship assessment		

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F 881	Continued From page 45 the infection, pharmacy orders-order name, order date, prescriber, and a place for comments. The tracking log identified residents that were identified with potential infections. Review of February 2025 infection control log identified R21 had been prescribed ciprofloxacin (an antibiotic) 500 milligram (mg) twice a day for four days for urinary tract infection (UTI). R21 had taken the medication from 2/7/25 through 2/11/25. R21's current, undated diagnosis sheet identified R21 had a diagnosis of neuromuscular dysfunction of the bladder (lack of bladder control due to brain, spinal cord or nerve problems). R21's current, undated care plan identified R21 had a risk of infection related to indwelling catheter (tube that collects urine from the bladder). The facility nursing staff was to evaluate R21 for urinary complaints and to manage patency of the catheter to minimize risk of infections. R21's progress notes identified on 2/07/25 at 1:12 p.m., R21 had symptoms of pain, discomfort and urinary retention. Nurse practitioner (NP) started orders for ciprofloxacin medication therapy related to UTI and prostatitis (inflammation of the prostate). R21's medical record lacked any initial comprehensive assessment. Interview on 5/14/25 at 4:03 p.m., with assistant director of nursing (ADON) identified the facility had used Loeb's criteria (surveillance for infections) for criteria for implementing antibiotics. Antibiotic time outs were placed under the assessment tab in the resident's record on Point	F 881	and MD notification (if needed) will begin weekly x 2 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and taken to QAPI for review and recommendation. Compliance: 06/25/2025		

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F 881	Continued From page 46 Click Care (PCC). This was not completed for R21. The ADON would expect an antibiotic time out to be reviewed and completed to determine continued need for residents on antibiotic therapy.	F 881			
F 883 SS=D	Review of current, undated Antibiotic Stewardship Procedure policy identified the facility was to record infections, gather clinical documentation, assess appropriateness of antibiotic use, and identify adverse outcome related to antibiotic use. Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or	F 883			6/25/25

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F 883	Continued From page 47 refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 (R28) were offered and/or provided updated vaccinations for pneumococcal disease, in accordance with Centers for Disease Control (CDC). Findings include: R28's 2/09/25, admission Minimum Data Set identified R28 was 79 years old and had a	F 883	R28 immunization consent was obtained, and then the resident subsequently refused. The resident immunization tab was updated with the resident refusal. All current residents immunizations were reviewed and updated as needed. Future residents who admit the immunization history will be reviewed upon admission and if eligible, residents will receive the immunization within 30 days of admission		

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F 883	Continued From page 48 diagnoses of dementia, anxiety and diabetes. R28 was offered but decline the pneumococcal vaccine (PCV). R28's current, undated immunization report indicated R28 had received PCV-7 on 2/16/11, PPV23 on 6/14/13, followed by PCV-13 on 7/12/19. Review of the current, 10/26/24, Centers for Disease Control (CDC): Pneumococcal Vaccine Recommendations, located at https://www.cdc.gov/pneumococcal/hcp/vaccine-recommendations/index.html, identified based on shared clinical decision-making, adults 65 years or older have the option to get PCV20 or PCV21, or to not get additional pneumococcal vaccines. They can get PCV20 or PCV21 if they have received both the PCV13 (but not PCV15, PCV20, or PCV21) at any age and a PPSV23 at or after the age of 65 years old. R28's 2/03/25, Revolving Immunization Consent or Declination form identified R28 consented for the PCV dose. Interview on 5/13/25 at 1:26 p.m., with the assistant director of nursing (ADON) identified the consent was obtained for R28 to receive the vaccine and was held. The ADON did not communicate with R28's power of attorney (POA) when the vaccine was held nor was R28 re-assessed to identify R28's appropriateness for the administration of the vaccine. Review of the current, undated Pneumococcal Vaccine policy indicated residents were to be assessed and receive the PCV vaccine within 30 days of admission. Residents were to receive the	F 883	unless immunization is refused. Licensed nurses will be in-serviced on the Pneumococcal Vaccine policy which indicates that residents will be assessed upon admission and will receive the vaccines unless medically contraindicated, previously given and/or refused and to provide documentation in the resident chart. The Director of Nursing is responsible for compliance. Audits on immunization being offered, acceptance or declination, and when immunization was given will begin weekly x 2 weeks then monthly to ensure compliance. Audit results will be reviewed by the Administrator and taken to QAPI for review and recommendation. Compliance: 06/25/2025		

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F 883	Continued From page 49 vaccines unless medically contraindicated, previously given and/or refused and to provide documentation in the resident's medical record of refusals.	F 883			

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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 5/12/25 through 5/14/25, 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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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

06/12/25

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed: H53784087 (MN104729) and H53784088C (MN103942). NO citations 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 completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE	2 000			

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2 000	Continued From page 2	2 000			
2 300	MN Rule 4658.0105 Competency A nursing home must ensure that direct care staff are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through the comprehensive resident assessments and described in the comprehensive plan of care, and are able to perform their assigned duties. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff were competent to use a continuous glucose monitoring device (FreeStyle Libre 3) for 1 of 1 resident (R)13 who had a diagnosis of diabetes. Findings include: R13's admission Minimum Data Set (MDS) assessment identified her cognition was intact, she required assistance from staff to complete activities of daily living (ADL)'s, and had diagnosis of diabetes, heart failure, respiratory failure, bi-polar disorder, borderline personality disorder, and depression. R13's May 2025, administration record identified she was to have her blood glucose level monitored and recorded three times a day before	2 300	Corrected		6/25/25

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2 300	Continued From page 3 meals. R13 was to be administered 40 units of insulin aspart protamine and insulin aspart (a combination of fast acting and intermediate acting insulin to keep blood sugar levels under control) subcutaneous two times a day at 8:00 a.m., and 4:00 p.m. In addition, R13 was to be administered a correction dose based on her blood sugar levels at the time of administration. R13's 4/30/25 through 5/13/25, documented blood glucose levels identified her blood sugars ranged from 70 Milligrams per deciliter (mg/dl)-403mg/dl. Target blood glucose levels for people with diabetes is 80-130mg/dl. Interview on 5/14/25 at 8:02 a.m., with registered nurse (RN)-B identified she was familiar with these types of devices similar to what R13 used for blood glucose monitoring because she had used them at other facilities. She revealed she had not received training on the device since working at this facility and had not completed a competency. She identified she did not know where the manufacturer directions were but thought they were on the charge nurse med cart or in the medication room. Interview on 5/14/25 at 8:07 a.m., with registered nurse (RN)-A identified he was the charge nurse and had never worked with a continuous blood glucose monitoring device. He was not aware of what type of device R13 used and was not aware if the facility had manufacturer directions or where they would be located if they did. He identified they may be on the other medication cart with R13's other medications. He revealed he had not been trained how to use the device and had not completed a competency. Interview on 5/14/25 at 1:04 p.m., with the	2 300			

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2 300	Continued From page 4 assistant director of nursing (ADON) identified the facility does not have a policy or process for the use of the FreeStyle Libre 3 continuous blood glucose monitoring device and had not completed any training or competencies to ensure nursing staff were knowledgeable and had an understanding of how the device worked. Interview on 5/14/25 at 8:15 a.m., with R13 identified she told the nurse what her blood sugar was. If R13's blood sugar was low they [nurses] gave R13 orange juice or a snack. R13 was not aware of any time that she would need to do a manual blood sugar check and was not familiar with how the alarms worked on the device. Interview on 5/14/25 at 4:11 p.m., with the administrator identified she would expect the facility would ensure nursing staff were trained and competent in the use of any medical equipment used for the treatment and medication therapy of residents who reside at the facility. Review of the FreeStyle Libre 3 manufacturer directions identified that prior to using the device, review all the product instructions and complete the interactive tutorial at www.FreeStyleLibre.com. In addition, the instruction identified there are symbols that may be displayed on the monitor screen to warn when a manual blood glucose level should be completed. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop and/or revise and implement policies and procedures related to nursing oversight and implement a training program for newly hired nursing staff. The administrator or designee should ensure oversight is provided to ensure appropriate	2 300			

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2 300	Continued From page 5 competency and orientation is provided upon hire, yearly, and as needed. The director of nursing or designee, should re-educate staff on the policies and procedures and have a system for evaluating and monitoring consistent implementation of these policies, with results of those audits being brought to the facility's Quality Assurance Committee for review to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 300	Corrected		6/25/25
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan that addressed anticoagulant (prevents and breaks down blood clots) therapy with safety precautions for 1 of 1 (R25) resident reviewed for care plan. Findings include: R25's 3/06/25, Significant change Minimum Data Set (MDS) identified R25 was admitted February 2025. R25 had a diagnosis of atrial fibrillation (irregular heart rhythm) and hip fracture. R25 was moderately cognitively impaired and had taken	2 565			

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2 565	Continued From page 6 anticoagulants on a routine basis. R25's current, undated Order Summary Report identified R25 was to receive Eliquis (anticoagulant used to prevent blood clots) 2.5 milligrams (mg) twice a day for atrial fibrillation. The order identified the medication was to start on 8/19/24. R25's current, undated care plan lacked individualized documentation of pharmacological and non-pharmacological interventions for R25, as well as, side effects and/or adverse effects of the medication use. Interview on 5/14/25 at 9:40 a.m., with registered nurse (RN)-A identified the risk of bleeding was an indicator of anticoagulant use. RN-A accessed R25's chart on Point Click Care (PCC), an online medical record, identified R25's care plan lacked evidence of monitoring for anticoagulation therapy. Interview on 5/14/25 at 9:53 a.m., with RN-B identified R25 was administered Eliquis and was to be monitored for symptoms such as, dark color stools, bruising, abnormal bleeding or severe paleness of the skin. RN-B had voiced agreement appropriate interventions should be reflected in R25's care plan. Interview on 5/14/25 4:06 p.m., with assistant director of nursing (ADON) identified R25's care plan should reflect interventions, including drug specific side effects for use of anticoagulant medications. Review of facility current, undated Care Plans, Comprehensive Person-Centered policy indicated care plans was to include services related to the	2 565			

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2 565	Continued From page 7 physical, mental and psychosocial well-being of the resident, measurable objectives and timeframes, and desired outcomes. The comprehensive care plan was to include ongoing assessments, revision of services, and interventions related to areas of concern. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should create and/or review or revise policies and procedures related to creating and implementing a comprehensive care plan as needed to ensure cares meet the specific needs of each individual resident. The director of nursing or designee should develop a system to educate staff and develop a monitoring system such as measurable audits to ensure individual care plans are created and implemented. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. The administrator should be responsible to ensure this occurs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565			
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection	21390			6/25/25

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21390	Continued From page 8 prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to complete a review of antibiotic therapy between 48-72 hours to ensure appropriateness of the continued use of an antibiotic for 1 of 3 (R21) sampled residents. Findings include: Review of the Centers for Disease Control (CDC) article, The Core Elements of Antibiotic Stewardship for Nursing Homes, Appendix A: Policy and Practice Actions to Improve Antibiotic Use, located at https://www.cdc.gov/antibiotic-use/core-elements/pdfs/core-elements-antibiotic-stewardship-appendix-a-508.pdf, identified facilities should evaluate the clinical signs and symptoms when a resident is first suspected of having an infection. Once the resident is placed on an antibiotic, they should	21390	Corrected		

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21390	Continued From page 9 be comprehensively reviewed within 48-72 hours after starting the medication to ensure they have been prescribed an effective medication. This is accomplished by reviewing the resident current symptoms and any laboratory results to identify medication effectiveness. The CDC identifies this process as an "antibiotic time-out." Review of the infection control logs from December 2024 through May 2025 identified the following areas of documentation: resident name, admit date, room number/unit, infection onset, type of infection, signs and symptoms, status of the infection, pharmacy orders-order name, order date, prescriber, and a place for comments. The tracking log identified residents that were identified with potential infections. Review of February 2025 infection control log identified R21 had been prescribed ciprofloxacin (an antibiotic) 500 milligram (mg) twice a day for four days for urinary tract infection (UTI). R21 had taken the medication from 2/7/25 through 2/11/25. R21's current, undated diagnosis sheet identified R21 had a diagnosis of neuromuscular dysfunction of the bladder (lack of bladder control due to brain, spinal cord or nerve problems). R21's current, undated care plan identified R21 had a risk of infection related to indwelling catheter (tube that collects urine from the bladder). The facility nursing staff was to evaluate R21 for urinary complaints and to manage patency of the catheter to minimize risk of infections. R21's progress notes identified on 2/07/25 at 1:12 p.m., R21 had symptoms of pain, discomfort and	21390			

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21390	Continued From page 10 urinary retention. Nurse practitioner (NP) started orders for ciprofloxacin medication therapy related to UTI and prostatitis (inflammation of the prostate). R21's medical record lacked any initial comprehensive assessment. Interview on 5/14/25 at 4:03 p.m., with assistant director of nursing (ADON) identified the facility had used Loeb's criteria (surveillance for infections) for criteria for implementing antibiotics. Antibiotic time outs were placed under the assessment tab in the resident's record on Point Click Care (PCC). This was not completed for R21. The ADON would expect an antibiotic time out to be reviewed and completed to determine continued need for residents on antibiotic therapy. Review of current, undated Antibiotic Stewardship Procedure policy identified the facility was to record infections, gather clinical documentation, assess appropriateness of antibiotic use, and identify adverse outcome related to antibiotic use. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies to ensure they contain a method for reviewing appropriate antibiotic use. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21390			

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21426	Continued From page 12 baseline TB screening is required for all healthcare workers (HCW). Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA.before hire. The second TST may be performed after the health care worker (HCW) starts working with patients. An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Review of employee health file for HK-A, identified HK-A was hired on 4/08/25 and completed a baseline TB symptom screen. HK-A's 4/08/25, Baseline TB Screening for HealthCare Workers (HCW) form indicated, HK-A had received both first and second TST tests on 4/08/25 at 8:20 a.m., and again at 9:30 a.m., which were read on 4/10/25 at 11:00 a.m., and aghain at 2:30 p.m., and were negative. The form indicated if the results of the first test were negative, the second TST series was to be completed in one to three weeks. Review of the current, undated Centers for Disease Control (CDC) Clinical Testing Guidance for Tuberculosis: Tuberculin Skin Test, located at https://www.cdc.gov/tb/hcp/testing-diagnosis/tuberculin-skin-test.html, identified if the first TB skin test result is negative, a second TB skin test	21426			

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21426	Continued From page 13 should be done 1 to 3 weeks later. If the second TB skin test result is positive, it is probably a boosted reaction. Based on this second test result, the person should be classified as previously infected. This would not be considered a skin test conversion or a new TB infection. However, the patient is a candidate for treatment for latent TB infection. If the second skin test result is negative, the baseline result is negative, and the person would be classified as uninfected. Interview on 5/14/25 at 1:09 p.m., HK-A stated she had received the first TST once hired. HK-A was not made aware a second TST was to be completed. Interview on 5/14/25 at 4:01 p.m., with ADON would expect new hires to complete all TB screening and testing, per facility policy. The ADON identified HK-A's TB form was filled out incorrectly and the employee did not recieve both TB series the same day. The ADON had no documentation to support HK-A had received a second TB test to complete the series and agreed this should be documented as completed. Review of May 2024 Tuberculosis, Employee Screening policy indicated the facility was to screen and test all employees for active TB prior to employment. SUGGESTED METHOD OF CORRECTION: The infection control nurse (ICN), director of nursing (DON) and/or designee should review policies and procedures related to the screening and testing for tuberculosis for residents and/or employees (staff). Facility staff could be educated on the TB regulations, symptom screening, and the two-step Mantoux process. The ICN, DON and/or designee could audit resident admissions	21426			

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21426	Continued From page 14 and/or staff new hires as well as current residents and/or staff records to ensure compliance. The ICN, DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty one-(21) days.	21426			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245378		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/12/2025	
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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 05/12/2025. At the time of this survey, Valley View Manor Hcc was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.			K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/12/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See 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. Valley View Manor Hcc The facility has a capacity of 50 beds and had a census of 32 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:			K 000			

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K 353 K 353 SS=F	Continued From page 2 Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to inspect and maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 8.5.6.4, 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.1.1.2, and 5.3.2.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 05/12/2025 at 2:45 PM, it was revealed by observation that the escutcheon plates were	K 353 K 353	Sprinkler heads were missing eustachian rings in housekeeping closet and therapy room. These rings were ordered on 5/13/25, received and installed on 5/27/25. The ceiling tile was replaced on 6/11/2025. All other areas were inspected and all the eustachian rings and ceiling tiles were present. Maintenance is responsible for sustained compliance. Audits on monthly eustachian ring and ceiling tile damage and replacement will begin monthly x 3 months to ensure compliance		6/25/25

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K 353	Continued From page 3 missing in the housekeeping closet. 2. On 05/12/2025 at 2:52 PM, it was revealed by observation that the escutcheon plates were missing in the Physical Therapy bathroom. 3. On 05/12/2025 at 3:35 PM, it was revealed by observation that there were missing ceiling tile in the basement corridor, guest room, and conference room. These deficient findings were confirmed by the Maintenance Supervisor at the time of discovery.			K 353	Audit results will be reviewed by the Administrator and taken to QAPI for review and recommendation. Compliance: 06/25/2025		
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 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 per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3 and failed to maintain the Utility System per NFPA 101 (2012 edition), Life Safety Code section 9.1.2 and NFPA 70 (2011 edition), National Electric Code, section 408.20. These deficient findings could have a widespread			K 511	Front hallway electrical panels that were not locked during survey were locked when identified by the surveyor and secured with screws 5/12/25. All other electrical panels were inspected, and no further action was needed. Audits on electrical panels being secured will begin monthly x 3 months to ensure		6/25/25

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K 511	Continued From page 4 impact on the residents within the facility. Findings include: 1. On 05/12/2025, at 3:10 PM, it was revealed by observation that the electrical panel located in the West Wing corridor was not secured. 2. On 05/12/2025, at 3:15 PM, it was revealed by observation that the electrical panel located in the East Wing corridor was not secured. These deficient findings were confirmed by the Maintenance Director at the time of discovery.	K 511	compliance Audit results will be reviewed by the Administrator and taken to QAPI for review and recommendation. Compliance: 06/25/2025		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs		PROVIDER # 245378	MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____	DATE SURVEY COMPLETE: 5/12/2025
NAME OF PROVIDER OR SUPPLIER VALLEY VIEW MANOR HCC		STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES			
K 920	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8, and UL 1363. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/12/2025 at 3:35 PM, it was revealed by observation that a toaster, microwave, and coffee pot were plugged into a power strip in the employee lounge. The Maintenance Director removed this deficient practice at the time of discovery. These deficient findings were confirmed by the Maintenance Director at the time of discovery			

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

The above isolated deficiencies pose no actual harm to the residents



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 3, 2025

Administrator
Valley View Manor HCC
200 East Ninth Avenue
Lamberton, MN 56152

Re: Reinspection Results
Event ID: GIQZ12

Dear Administrator:

On July 1, 2025 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 May 14, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112



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Electronically Delivered
July 3, 2025

Administrator
Valley View Manor HCC
200 East Ninth Avenue
Lamberton, MN 56152

RE: CCN: 245378
Cycle Start Date: May 14, 2025

Dear Administrator:

On July 1, 2025, 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,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112