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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: H90X

Facility ID: 00750

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245423**

2. STATE VENDOR OR MEDICAID NO. (L2) **925340800**

3. NAME AND ADDRESS OF FACILITY
(L3) **CHOSEN VALLEY CARE CENTER**
(L4) **1102 LIBERTY STREET SOUTHEAST**
(L5) **CHATFIELD, MN** (L6) **55923**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **10/28/2016** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **09/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **78** (L18)

13.Total Certified Beds **78** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	78			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 11/09/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 11/09/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION **02/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS
Posted 11/15/2016 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245423

November 9, 2016

Mr. Craig Backen, Administrator
Chosen Valley Care Center
1102 Liberty Street Southeast
Chatfield, MN 55923

Dear Mr. Backen:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective October 25, 2016 the above facility is certified for:

78 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 78 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
November 9, 2016

Mr. Craig Backen, Administrator
Chosen Valley Care Center
1102 Liberty Street Southeast
Chatfield, MN 55923

RE: Project Number S5423026

Dear Mr. Backen:

On October 4, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 15, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On October 28, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 15, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 25, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 15, 2016, effective October 25, 2016 and therefore remedies outlined in our letter to you dated October 4, 2016, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245423 Y1	A. Building B. Wing Y2	10/28/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOSEN VALLEY CARE CENTER	1102 LIBERTY STREET SOUTHEAST CHATFIELD, MN 55923

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0157	Correction	ID Prefix F0282	Correction	ID Prefix F0314	Correction
Reg. # 483.10(b)(11)	Completed	Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25(c)	Completed
LSC	10/25/2016	LSC	10/25/2016	LSC	10/25/2016
ID Prefix F0323	Correction	ID Prefix F0325	Correction	ID Prefix F0334	Correction
Reg. # 483.25(h)	Completed	Reg. # 483.25(i)	Completed	Reg. # 483.25(n)	Completed
LSC	10/25/2016	LSC	10/25/2016	LSC	10/25/2016
ID Prefix F0441	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.65	Completed	Reg. #	Completed	Reg. #	Completed
LSC	10/25/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	KS/kfd	11/9/2016	03048	10/28/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
9/15/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245423	A. Building 01 - MAIN BUILDING 01 B. Wing	11/9/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOSEN VALLEY CARE CENTER	1102 LIBERTY STREET SOUTHEAST CHATFIELD, MN 55923

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0018	Correction Completed 10/25/2016	ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 10/25/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)** TL/kfd	**DATE** 11/9/2016	**SIGNATURE OF SURVEYOR** 37008	**DATE** 11/9/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 9/21/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: H90X

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00750

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245423**

2. STATE VENDOR OR MEDICAID NO. (L2) **925340800**

3. NAME AND ADDRESS OF FACILITY
(L3) **CHOSEN VALLEY CARE CENTER**
(L4) **1102 LIBERTY STREET SOUTHEAST**
(L5) **CHATFIELD, MN** (L6) **55923**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **09/15/2016** (L34)

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC 2 AOA 3 Other

FISCAL YEAR ENDING DATE: (L35) **09/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **78** (L18)

13.Total Certified Beds **78** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	78			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date : Wendy Willson, HFE NE II 10/13/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: Kamala Fiske-Downing, Enforcement Specialist 10/18/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

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23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
October 4, 2016

Mr. Craig Backen, Administrator
Chosen Valley Care Center
1102 Liberty Street Southeast
Chatfield, MN 55923

RE: Project Number S5423026

Dear Mr. Backen:

On September 15, 2016, a standard 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the September 21, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5423015 and H5423016 that were found to be unsubstantiated.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 25, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a 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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by December 15, 2016 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 15, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING _____ B. WING _____	09/15/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS 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. Electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. "A recertification survey was conducted and complaint investigation(s) were also completed at the time of the standard survey. " An investigation of complaints H5423015 and H5423016 was completed and found not to be substantiated.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge	F 157		10/25/16

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

Electronically Signed | 10/13/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING _____ B. WING _____	09/15/2016

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

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F 157	Continued From page 1 the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, document review and staff interview the facility failed to notify the physician of the significant weight loss experienced for 1 of 3 residents (R69) reviewed for nutrition. Findings include: R69 was admitted on 4/12/16, with diagnoses that included GERD (gastroesophageal reflux disease), peptic ulcer, dementia, stage 3 kidney disease, anxiety and depression. R69's quarterly Minimum Data Set (MDS) assessment identified R69 with a Brief Interview for Mental Status (BIMS) score of 4 indicating severe cognitive impairment and identified he was independent with eating with only set up assistance needed. The nutrition section of the MDS identified R69 with a weight of 227 pounds and indicated no nutritional problems.	F 157	This plan and response to MCS-2567 regarding Tag F 157, is written solely to maintain certification in the Medicare and Medical Assistance programs. We wish to preserve our right to dispute these findings in their entirely should any remedies be imposed. Chosen Valley Care Center continues to promptly notify the resident, his or her Attending Physician, and representative of changes in residents□ medical/mental condition and/or status. Chosen Valley Care Center'□s Change in a Resident□s Condition of Status Policy has been reviewed. R69□'s physician was notified on October 10, 2016 of weight loss, current weight and result of food intake log.	

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F 157	Continued From page 2 During review of R69's medical record, height and weight tracking R69 was noted to have sustained a significant weight loss since admission and more specifically within the past two months (7/1/16-9/6/16). R69's weight record (most current) indicated the following weights: 9/6/16-199.8 pounds (lbs) which identified R69 with a 10% weight loss since admission. 8/1/16-214.0 lbs which indicated a 5% weight loss since 7/1/2016. 7/1/16-227.0 lbs 6/2/16-223.0 lbs 5/10/16-224.0 lbs 5/1/16- 230.0 lbs 4/14/16-224.0 lbs 4/13/16-225.0 lbs During observation on 9/13/16, at 5:09 p.m. R69 was seated at the dining room table in his wheelchair. R69 was served a lemon bar, 1 buttered bread slice, boiled potatoes and spinach. R69 was observed to consume less than 1/2 of the evening meal. R69 was noted to sit at the table for a long time period just looking around the dining room. During observation of the brunch meal on 9/14/16, at 12:00 p.m. R69 was served the following food items: 2 strips of bacon, 1 buttered toast slice, hash brown triangle, soup and half a turkey sandwich. At 12:45 p.m. when R69 left the dining room it was noted he consumed 1/4 piece of bacon, 1/2 piece of toast, 1/2 hash brown triangle, none of the turkey sandwich and had consumed approximately 2 bites of soup. When the certified dietary manager (CDM) observed the tray she stated,"Well, he did not eat very good. He is like that sometimes."	F 157	All residents who reside at Chosen Valley Care Center have the potential to be affected by this deficient practice. All Licensed staff have been re-educated on the Change in Resident□s Condition or Status Policy in shift report. All staff will be in-serviced on October 20th, 21st, and 24th, 2016 on our Change in Resident□s Condition or Status Policy. Physician Notification Audit will be completed by the Certified Dietary Manager or her designee monthly for two months and then quarterly audits will be completed and presented at the Quality Improvement Meeting for one full year.	

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Progress notes related to to R69's nutritional status were as noted:
(1) A dietary note dated 5/3/16, at 6:16 a.m. identified R69 as an 88 yr old male with diagnoses as: HTN (hypertension), KD (kidney disease) and CHF (congestive heart failure). It was identified that R69 was administered Lasix (diuretic) medication due to diagnosis of edema and was at risk for dehydration. R69's diet was documented as No Added Salt (NAS) diet. R69 was independent with eating and intake greater than 75% of meals R69 had upper dentures and own teeth on lower jaw. No chewing nor swallowing problems documented. His weight and height were recorded as 230 lbs and 70 inches (5' 10").

(2) A dietary note dated 6/7/16, at 6:36 a.m. identified R69 with the following diagnoses: falls, advanced dementia, Stage III KD (kidney disease). Medications reviewed on physician's orders included Lasix (diuretic) due to diagnosis of edema and at risk for dehydration. R69 was identified as independent with eating and intake usually consuming greater than 75% of his food. No chewing or swallowing problems; weight documented as 223 lbs. and weight within usual range. The note also identified R69 was at risk due to diagnoses with need for NAS diet, due to multiple meds, due to body weight (BW) and BMI high and due to abnormal labs. The note identified staff to monitor intake, weights and hydration per policy/MD order; notify CDM, RD as needed.

(3) A quarterly assessment/dietary note dated 7/12/16, at 11:11 a.m. identified R69's weight at 227 lbs., provided a NAS diet related to heart

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F 157	Continued From page 4	F 157		

failure, consumed 75-100% of meals served and that R69 would try to eat his wife's food, who sat with him at the dining room table. The note also identified that R69 would refuse to eat at times and would want to go back to room. There were no chewing or swallowing problems identified and the care plan was reviewed with no changes in goals or approaches.

The medical record lacked any further documentation related to dietary status/weight loss other than weight recordings. R69 experienced a 27 lb. weight loss since the recorded weight of 227 lbs on 7/1/16 and 198.9 lbs on 9/6/16. The medical record lacked any evidence of physician notification of the significant weight loss.

When interviewed on 9/14/16, at 11:22 a.m. the certified dietary manager (CDM) was questioned about R69's recorded weight loss of 27 lbs since 7/1/16. The CDM indicated she was unaware of the weight loss and questioned whether the weight recorded was wrong. The CDM stated R69's weight loss might have been related to some dental work completed recently and/or related to the administration of Lasix (diuretic). The CDM stated that ongoing weights had been monitored but she had not identified R69's weight loss as a concern. She also stated the weight loss could have been related to R69's new wheelchair. The CDM further identified the registered dietician (RD) had consulted at the facility on 8/4/16 and 9/13/16 and verified that R69 had not been listed for RD review related to any weight loss.

When interviewed on 9/14/16, at 11:27 a.m. registered nurse (RN)-C stated she was unaware

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of the weight loss and had not been notified. RN-C stated she would not have identified the weight loss until the next quarterly assessment was conducted and she would expect to be notified.

When interviewed on 9/14/16, at 11:59 a.m. the director of nursing (DON) verified nursing staff should have reported/responded to the weight loss to the physician and verified the RD should also have been been notified of the weight loss. The DON stated she was unaware of the weight loss.

On 9/14/16, at 12:05 p.m. the RD was contacted via phone. The RD was unaware of R69's weight loss and stated she did not recall reviewing R69's record when she was at the facility on 8/4/16 and 9/13/16. The RD stated she would expect the staff make her aware of significant weight loss but would not comment any further as she did not have R69's medical record to review.

During interview with registered nurse (RN)-A on 9/14/16 at 1:46 p.m. RN-A stated she would expect to be notified if any resident sustained a significant weight loss. RN-A indicated she would proceed to request staff reweigh the resident for accuracy and look for non-health related conditions for the significant change in weight.

The facility policy "Change in Resident's Condition or Status", revised September 2013, identified in the Policy Statement; The facility shall promptly notify the resident, his or her attending physician, and representative of changes in the resident's medical/mental condition and/or status.
Policy Interpretation and Implementation:

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F 157	Continued From page 6 (1) The nurse supervisor/charge nurse will notify the resident's attending physician or on-call physician when there has been: a. An accident or incident involving the resident b. A discovery of injuries of unknown origin. c. A reaction to medication d. A significant change in the resident's physical/emotional/mental condition. e. A need to alter the resident's medical treatment significantly. f. Refusal of treatment or medications g. A need to transfer the resident to a hospital or treatment center. h. A discharge without proper medical authority. i. Instructions to notify the physician of changes in the resident's condition. (2) A "Significant change" of condition is a decline or improvement in the resident's health status that: a. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions. b. Impacts more than one area of the residents health status. c. Requires interdisciplinary review and/or revision to the care plan; and d. Ultimately is based on the judgement of the clinical staff and the guidelines outlined in the Resident Assessment Instrument [RAI].	F 157		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282		10/25/16

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F 282	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to implement the plan of care to reduce the risk of injury during falls for 1 of 4 residents (R69) reviewed for falls. Findings include: R69 was admitted on 4/12/16. The quarterly Minimum Data Set (MDS) assessment dated 7/10/16, identified R69 with a Brief Interview for Mental Status (BIMS) score of 4 indicating a severe cognition deficit. The MDS further identified R69 required limited assistance of one staff with toileting and transfers. Also, the MDS identified R69 had sustained 2 or more falls since his admission and had sustained minor injuries with 2 or more falls. Fourteen falls were documented in progress notes from 4/12/16 until 9/13/16 which identified that R69 attempted self transfers and/or self-cares repeatedly since admission. On 9/13/16 at 3:55 p.m. a progress note identified R69 was found by staff sitting on his floor, with chair alarm sounding, between his wheelchair and recliner. The note identified R69 was attempting to self transfer without assistance. The interdisciplinary team (IDT) progress note dated 9/14/16, at 8:34 a.m. identified current fall interventions to include: (1) gripper socks at bedtime and when wearing shoes; (2) hip protestors at all times; (3) door/curtain open as able for increased supervision; (4) every 1 hour checks while in room; (5) offer toileting (every 30 minutes for increased confusion); (6) morning cares/dressing assistance at 5:00 a.m.-5:30 a.m.; (7) offer evening cares right after supper; (8)	F 282	This plan and response to MCS-2567 regarding Tag F 282, is written solely to maintain certification in the Medicare and Medical Assistance programs. We wish to preserve our right to dispute these findings in their entirely should any remedies be imposed. The policies and procedures for implementation of care plans and care planning have been reviewed and found appropriate. After it was known that the resident□s (R69) plan of care to reduce the risk of injury during falls was not being followed, the nursing assistants were educated on Resident 69□'s fall interventions that are to be followed. They were re-educated on the locations of the care plans and where to find fall interventions on the care plan for all residents. All residents who reside at Chosen Valley Care Center have the potential to be affected by this deficient practice. Nursing Assistants, Nurses, and TMAs have initially been notified in shift report of the expectations of following fall interventions according to plan of care, what the outcomes could be of not following care plans, where to identify residents□ fall interventions and who to see if there are questions regarding care plans. All licensed and unlicensed staff will be re-educated on resident care plans	

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F 282	Continued From page 8 personal safety alarm at all times; (9) keep walker at bedside and (10) place dicem above and below wheelchair cushion. These were identified on the care plan dated 7/21/16 as R69 had impaired mobility related to increased weakness and impaired balance secondary to dementia and history of trans-ischemic attacks (TIA's) and required assistance ambulation and positioning and R69 utilized a wheelchair or walker for mobility. During observation of a morning cares on 9/13/16, at 5:41 p.m. NA-A entered R69's room to answer the call light and noted R69 attempting to enter the bathroom. NA-A was observed to remove R69 away from the bathroom door in his wheelchair and leave the room. After staff left the room, R69 immediately wheeled himself back into the bathroom and attempted independent toileting. R69 attempted to stand which activated the chair alarm. At 5:45 p.m. registered nurse (RN)-A responded to the activated alarm sound and entered the room and to assist R69 to pivot onto the toilet. It was observed that when R69 stood in front of the toilet, he was shaky and unable to pivot self and sit on toilet without assistance. When interviewed on 9/13/16, at 5:50 p.m. NA-A stated she had to leave the room to locate staff to assist R69 to the bathroom. NA-A stated she was aware R69 was at risk for falling and required assistance to toilet. During this observation R69 did not have his hip protectors attached as directed by his care plan. During a subsequent interview on 9/13/16, at 6:33 p.m. RN-A stated NA-A should have stayed with R69 and called someone to help her. RN-A stated, "He [R69] is a huge fall risk". RN-A stated	F 282	with emphasis on Fall Interventions at all staff in-services on October 20th, 21st, and 24th, 2016. A Fall Intervention Audit was developed and will be completed to ensure that fall interventions are followed according to plan of care to reduce the risk of injury during falls. The Director of Nursing or her designee will complete these monitors once weekly for four weeks and then quarterly audits will be completed and presented at the Quality Improvement Meeting for one full year.	

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F 282	Continued From page 9 staff definitely needed more training as it was not acceptable to leave R69 alone when staff are aware he will attempt to self transfer. When interviewed on 9/13/16, at 6:50 p.m. NA-B verified when she undressed R69 for bedtime cares he did not have his hip protectors on and further indicated she was unaware whether he had worn them during the entire shift. NA-B further stated that R69 would often refuse to put the hip protectors on. During interview with RN-C on 9/15/16 at 8:56 a.m. she stated the care plan had just been changed to reflect that R69 often would refuse the use of the hip protectors. RN-C verified the care plan interventions had indicated that R69 should wear hip protectors at all times. No policy related to Fall intervention was received from facility staff.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 314	This plan and response to MCS-2567	10/25/16

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F 314	Continued From page 10 review the facility failed to comprehensively reassess and implement timely interventions for 1 of 1 resident (R9) reviewed who developed a Stage III pressure ulcer located on the ankle. Findings include: A significant change Minimum Data Set (MDS) assessment dated 1/10/16, identified R9 as being at risk for pressure ulcers (PU) but had no (0) pressure ulcers at this time. The Care Area Assessment (CAA) dated 1/12/16, identified R9 at mild risk for PU secondary to requiring extensive assistance with bed mobility (2 staff) and frequently incontinent of bowel and bladder. The CAA identified no open areas (skin) nor areas of concern and the interventions included the use of pressure reducing cushion in w/c (wheelchair), lip mattress on bed, turn and reposition every 2 hours. However, on the quarterly MDS assessment dated 6/26/16, a stage II pressure ulcer was identified. During observation on 9/15/2016, at 8:31 a.m. R9 was noted lying in bed on her back. R9 had gripper socks on but no heel protectors and heels/feet were not floated as pillow was under her knees. At 8:33 a.m. licensed practical nurse (LPN)- A verified R9's heels/feet were not floated and R9 did not have heel protectors on. No heel protectors were found in R9's room. Review of the care plan dated 6/3/16, identified interventions that included: (1) staff were to offload R9's heels and ankles when in bed, (2) turn and reposition every two hours when in bed or chair and (3) give 4 ounces of Resource 2.0 (a calorie and protein dense drink appropriate for wound prevention and treatment programs) 4 times per day. The current care plan did not	F 314	regarding Tag F 314, is written solely to maintain certification in the Medicare and Medical Assistance programs. We wish to preserve our right to dispute these findings in their entirely should any remedies be imposed. Chosen Valley Care Center strives to ensure that based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual□s clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. The policies and procedures for comprehensively assessing the residents□ skin condition and risk factors have been reviewed and found appropriate. The care plan was updated on October 11, 2016 for R9 to reflect the current interventions required to prevent further deterioration and promote healing of the ankle ulcer. R9 was recently seen by podiatrist on October 3, 2016 and ulcer measures 3mm x 3mm x 1mm. Per podiatrist note, ulcer has no odor, no undermining, no tunneling or pain and ulcer is improving. All residents who reside at Chosen Valley	

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F 314	Continued From page 11 identify the current Stage III PU located on the right ankle nor had it been updated to reflect the use of the heel protector. Review of the Braden scale for predicting PU risk dated 6/23/16, did not identify the pressure ulcer. No further Braden scale assessments were conducted since 6/23/16 nor any other reassessments (e.g. tissue tolerance) related to the PU. Review of the Weekly Skin Charting was as noted: 4/16/16- bruise to right outer ankle measuring 0.6 by 0.6 centimeters (cm) and fluid filled. A note was sent to the physician. No new intervention implemented. 4/23/16- area to right outer ankle measures 0.6 cm by 0.6 cm and is cleansed with normal saline (NS) and covered with foam dressing. 4/30/16- PU to right outer ankle, area is dark, measured 0.3 by 0.3 cm, no drainage and covered with foam and changed every three days. 5/7/16- area to right ankle measures 1 cm by 1 cm, covered with foam. No changes in plan of care with increase in size from 0.3 to measurement of 1 cm. 5/14/16-scabbed area to right ankle measures 1 cm by 1 cm. 5/23/16- wound/scab area to outer right ankle measures 1 cm by 1 cm and covered with a foam pad. 5/29/16-continues to have scabbed area to right ankle measuring 1 by 1 cm. 6/11/16-duoderm (colloid dressing) over right ankle (no measurements of ulcer). 7/9/16-continues to have open area to right outer ankle. 8/27/16-right ankle measured 0.5 by 0.5 cm. 9/3/16-right ankle ulcer continues and measured 0.3 by 0.4 by 0.1 cm. Stage III (a full thickness	F 314	Care Center have the potential to be affected by this deficient practice. A wound committee will meet every two weeks. The committee includes: RN Case Managers, RN Nurse Manager, DON, and the CDM. The first meeting is scheduled for October 13, 2016. All staff will be educated on October 20th, 21st, and 24th, 2016 on our Pressure Ulcer Treatment Policy which includes reassessing a resident once they have developed a pressure ulcer and implementing the appropriate interventions once assessment is completed. Pressure Ulcer Intervention Audit will be completed by the Director of Nursing or her designee once weekly for four weeks and then quarterly audits will be completed and presented at the Quality Improvement Meeting for one full year.	

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F 314	Continued From page 12 tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of the tissue loss. May include undermining and tunneling). Review of the Pressure Ulcer Weekly Flow Sheet is as follows for the right ankle: 6/4/16-0.8 cm by 0.8 cm, no depth, Stage II pressure ulcer (partial thickness skin loss involving epidermis and or dermis. Superficial and presents as abrasion, blister or shallow crater). Treatment: cleanse with normal saline (NS) apply Aquacel and cover with Duoderm every 3 days and as needed (prn). 6/19/16-0.5 cm by 0.4 cm, no depth, Stage II; No change in treatment. 6/25/16-0.7 by 0.5 cm, no depth, Stage II; No change in treatment. 7/2/16-0.8 by 0.9 cm, no depth, Stage II; No change in treatment. 7/16/16- 0.9 by 0.6 cm, no depth, Stage II; Change in treatment: NS, apply collagen gel, Aquacel and non-adhesive foam dressing every 3 days and prn. 7/23/16-0.8 by 0.8 cm by 0.1 cm depth, Stage III; No reassessment documented with change in PU from Stage II to Stage III nor change in treatment. 7/30/16-0.8 cm by 0.8 cm by 0.1 cm depth, Stage III; No change in treatment plan. 8/7/16-0.8 by 0.7 by 0.1 cm depth, Stage III; Treatment changed: Apply antibiotic ointment to ulcer on right ankle, cover with Aquacel and Duoderm and change every 5 days and prn. 8/14/16-0.8 by 0.8 by 0.1 cm depth, Stage III; Same treatment. 8/20/16-0.5 by 0.5 cm by 0.1 cm depth, Stage III; Continue same treatment. 9/3/16- 0.3 by 0.4 by 0.1 cm depth, Stage III.	F 314		

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F 314	Continued From page 13 9/17/16-0.4 by 0.4 cm, no depth, healing, Stage III. When interviewed on 9/14/16, at 1:04 p.m. registered nurse (RN)-A verified that R9 was identified to be at risk for developing pressure ulcers and developed a Stage III pressure ulcer to the right ankle after admission to the facility. RN-A confirmed no further reassessments were conducted during the time when the pressure ulcer had deteriorated from a Stage II to Stage III. Although the treatments were changed, the plan of care did not reflect the current interventions required to prevent further deterioration and/or promote healing of the ankle PU. The undated facility policy titled, Pressure Ulcer Treatment indicated the following protocol for the care of an existing pressure ulcer: (9) Start Tissue Tolerance Evaluation and notify nurses on communication board; (10) Change care plan for resident to be repositioned every 1 hour while in bed and chair; (11) Pressure ulcer to monitored at minimum once daily; (12) Re-evaluate supportive surfaces and determine if new interventions are indicated; (13) Treatment to be re-evaluated at minimum every 14 days for effectiveness. If no improvement re-evaluate nutritional support/off-loading/redistribution devices and new treatment; and (14) If Pressure Ulcer progresses notify physician immediately and follow staging protocols.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	F 323		10/25/16

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F 323	Continued From page 14 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide care in a manner to reduce the risk of fall and injury for 1 of 4 residents (R69) reviewed for accidents. Findings include: R69 was admitted on 4/12/16. The quarterly Minimum Data Set (MDS) assessment dated 7/10/16, identified R69 with a Brief Interview for Mental Status (BIMS) score of 4 indicating a severe cognition deficit. The MDS further identified R69 required limited assistance of one staff with toileting and transfers. Also, the MDS identified R69 had sustained 2 or more falls since his admission and had sustained minor injuries with 2 or more falls. Multiple falls were documented and progress notes identified that R69 attempted self transfers and/or self-cares repeatedly as noted: (1) On 9/13/16, at 3:55 p.m. R69 found by staff sitting on his floor, with chair alarm sounding, between his wheelchair and recliner; attempting to self transfer without assistance. (2) On 8/30/16, at 6:55 a.m. R69 was seated on the patio outside the front door and was attempting to wheel himself back in the facility when his wheelchair cushion slipped out of his wheelchair and R69 slid out with cushion onto the patio. No injury noted.	F 323	This plan and response to MCS-2567 regarding Tag F 323, is written solely to maintain certification in the Medicare and Medical Assistance programs. We wish to preserve our right to dispute these findings in their entirely should any remedies be imposed. The policies and procedures for falls, which includes fall interventions, have been reviewed and found appropriate. On September 13, 2016 it became known that NA-A, who had been training, had answered R69 call light then left the resident□s room to find assistance. NA-A received verbal education to educate her how she should have safely handled the situation. Additionally the nursing assistants were educated on Resident 69□s fall interventions that are to be followed. They were re-educated on the locations of the care plans and where to find fall interventions on the care plan for all residents. Additionally resident□s care plan had been updated on September 15, 2016 to reflect that resident R69 often refuses use of hip protectors. All residents who reside at Chosen Valley Care Center have the potential to be	

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F 323	Continued From page 15 (3) On 8/19/16, at 6:00 p.m. R69's bed alarm was heard sounding and when staff entered room R69 was observed sitting on the floor in his room; appeared to be trying to get ready for bed. (4) On 8/3/16, at 4:00 a.m. R69's alarm sounded, staff responded and R69 was observed sitting on the floor in the middle of his room; attempted to self ambulate to the bathroom by himself. (5) On 8/2/16, at 10:30 a.m. a nursing assistant (NA) was assisting R69 to the toilet with the use of a gait belt, R69 attempted to sit before reaching the toilet and was lowered to the floor. (6) On 7/31/16, at 4:39 a.m. R69's alarm was sounding, staff arrived at the room R69 was witnessed to fall backwards and land on floor beside bed; received abrasions which required treatment. (7) On 7/29/16, at 11:30 R69 was walking from his bed to the bathroom with use of walker without assistance and fell backwards into his bedside table; received two skin tears -required nursing treatment. (8) On 7/29/16, at 12:15 p.m. R69 fell again, toileted without assistance. (9) On 7/13/16, at 6:28 p.m. R29 was found on the floor by his wife after returning from the evening meal. (10) On 7/5/16, at 9:10 a.m. R69 was was found lying on his back in the middle of his room with his pants around his ankles; sustained a laceration to his left wrist. (11) On 6/22/16, at 2:18 p.m. R69 was found on the floor in his bathroom; stated he was going to the bathroom. (12) On 5/23/16, at 8:49 a.m. R69 was found on the floor in his room in front of his recliner.(13) On 5/16/16, at 9:30 a.m. R69 was found sitting on the floor in his room yelling for help. (14) On 4/12/16 at 5:19 p.m. R69 was found seated on the floor in	F 323	affected by this deficient practice. Nursing Assistants, Nurses, and TMAs have initially been notified in shift report of the expectations of following fall interventions according to plan of care, what the outcomes could be of not following care plans, where to identify residents fall interventions, what to do if a resident refuses care or interventions, and who to see if there are questions regarding care plans. All licensed and unlicensed staff will be re-educated on resident care plans with emphasis on Fall Interventions on October 20th, 21st, and 24th, 2016. A Safe Environment Audit was developed and will be completed to ensure that resident environments are free of potential accidents to reduce the risk of falls and/or injury. This monitor includes observing staff answering call lights to ensure that all interactions are completed safely and all potential hazards are identified. The Director of Nursing or her designee will complete these audits once weekly for four weeks and then quarterly audits will be completed and presented at the Quality Improvement Meeting for one full year.	

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F 323	Continued From page 16 his bathroom. During observation of a morning cares on 9/13/16, at 5:41 p.m. NA-A entered R69's room to answer the call light and noted R69 attempting to enter the bathroom. NA-A was observed to remove R69 away from the bathroom door in his wheelchair and leave the room. After staff left the room, R69 immediately wheeled himself back into the bathroom and attempted independent toileting. R69 attempted to stand which activated the chair alarm. At 5:45 p.m. registered nurse (RN)-A responded to the activated alarm sound and entered the room and to assist R69 to pivot onto the toilet. It was observed that when R69 stood in front of the toilet, he was shaky and unable to pivot self and sit on toilet without assistance. When interviewed on 9/13/16, at 5:50 p.m. NA-A stated she had to leave the room to locate staff to assist R69 to the bathroom. NA-A stated she was aware R69 was at risk for falling and required assistance to toilet. During this observation R69 did not have his hip protectors attached as directed by his care plan. During a subsequent interview on 9/13/16, at 6:33 p.m. RN-A stated NA-A should have stayed with R69 and called someone to help her. RN-A stated, "He [R69] is a huge fall risk". RN-A stated staff definitely needed more training as it was not acceptable to leave R69 alone when staff are aware he will attempt to self transfer. When interviewed on 9/13/16, at 6:50 p.m. NA-B verified when she undressed R69 for bedtime cares he did not have his hip protectors on and stated she was not aware whether he had them	F 323		

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F 323	Continued From page 17 on the entire shift. NA-B further stated that R69 would often refuse to put the hip protectors on. R69's care plan dated 7/21/16, identified R69 had impaired mobility related to increased weakness and impaired balance secondary to dementia and history of trans-ischemic attacks (TIA's) and required assistance ambulation and positioning and R69 utilized a wheelchair or walker for mobility. The following interventions to reduce fall risk included: (1) assist of one staff to walk with walker; (2) one staff assistance to put gripper socks on at bedtime; (3) call light is always within reach; (4) check every 1 hour in room to ensure needs have been met and offer toileting; (5) if refusal of care have another staff attempt to assist; (6) offer evening care right after supper to avoid attempt to independently perform cares and risk of falling; (7) monitor for signs and symptoms of unsteady gait, unsteady balance, poor posture, leaning, tilting, dizziness, fatigue, poor/double vision; (8) teach and remind to rise slowly from sitting or laying positions to avoid dizziness; (9) conduct fall assessment at least quarterly, checking ambulation, balance blood pressure, bowel and bladder issues, coordination, diagnoses, endurance, history of fall, mental status, medications and vision; and (10) hip protectors on at all times. The interdisciplinary team (IDT) progress note dated 9/14/16, at 8:34 a.m. identified current fall interventions to include: (1) gripper socks at bedtime and when wearing shoes; (2) hip protestors at all times; (3) door/curtain open as able for increased supervision; (4) every 1 hour checks while in room; (5) offer toileting (every 30 minutes for increased confusion); (6) morning cares/dressing assistance at 5:00 a.m.-5:30 a.m.;	F 323		

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F 323	Continued From page 18 (7) offer evening cares right after supper; (8) personal safety alarm at all times; (9) keep walker at bedside and (1) place dicem above and below wheelchair cushion. During interview with RN-C on 9/15/16 at 8:56 a.m. she stated the care plan had just been changed to reflect that R69 often would refuse the use of the hip protectors. RN-C verified the care plan interventions had indicated that R69 should wear hip protectors at all times. No policy related to Fall intervention was received from facility staff.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a significant weight loss was identified and evaluated so the necessary interventions could be implemented for 1 of 3 resident (R69) reviewed for nutrition and experienced significant weight loss.	F 325	This plan and response to MCS-2567 regarding Tag F 325, is written solely to maintain certification in the Medicare and Medical Assistance programs. We wish to preserve our right to dispute these findings in their entirely should any	10/25/16

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F 325	Continued From page 19 Findings include: R69 was admitted on 4//12/16, with diagnoses that included GERD, peptic ulcer, hypertension, dementia, stage 3 kidney disease, anxiety and depression. R69's quarterly Minimum Data Set (MDS) assessment identified R69 with a Brief Interview for Mental Status (BIMS) score of 4 indicating severe cognitive impairment and identified he was independent with eating with only set up assistance needed. The nutrition section of the MDS identified R69 with a weight of 227 pounds and indicated no nutritional problems. During review of R69's medical record, height and weight tracking R69 was noted to have sustained a significant weight loss since admission and more specifically within the past two months (7/1/16-9/6/16). R69's weight record indicated the following weights: 9/6/16-199.8 pounds (lbs) which identified R69 with a 10% weight loss since admission. 8/1/16-214.0 lbs which indicated a 5% weight loss since 7/1/2016. 7/1/16-227.0 lbs 6/2/16-223.0 lbs 5/10/16-224.0 lbs 5/1/16- 230.0 lbs 4/14/16-224.0 lbs 4/13/16-225 Lbs During observation on 9/13/16, at 5:09 p.m. R69 was seated at the dining room table in his wheelchair. R69 was served a lemon bar, 1 buttered bread slice, boiled potatoes and spinach. R69 was observed to consume less than 1/2 of the evening meal. R69 was noted to sit at the	F 325	remedies be imposed. Chosen Valley Care Center will continue to ensure that all residents maintain an acceptable parameter of nutritional status, such as body weight and protein levels, unless the resident□s clinical condition demonstrates that this is not possible. The Weight Assessment and Intervention Policy has been reviewed and found appropriate. New food intake was completed for R69 on October 9, 2016. The new intake revealed that R69 consumes 75% of his meals. On October 5, 2016 a new weight was obtained and R69□s current weight is 210.4 pounds. All residents who reside at Chosen Valley Care Center have the potential to be affected by this deficient practice. Nursing Assistants, Nurses, and TMAs have been re-educated on the Weight Assessment and Intervention Policy in shift report. All licensed and unlicensed staff will be re-educated on our Weight Assessment and Intervention Policy which includes what actions need to be taken if a weight loss is determined on October 20th, 21st, and 24th, 2016. Weight Loss Intervention Audit will be completed by the Certified Dietary Manager or her designee monthly for two months and then quarterly audits will be completed and presented at the Quality	

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F 325	Continued From page 20 table for a long time period just looking around the dining room. During observation of the brunch meal on 9/14/16, at 12:00 p.m. R69 was served the following food items: 2 strips of bacon, 1 buttered toast slice, hash brown triangle, soup and half a turkey sandwich. At 12:45 p.m. when R69 left the dining room it was noted he consumed 1/4 piece of bacon, 1/2 piece of toast, 1/2 hash brown triangle, none of the turkey sandwich and had consumed approximately 2 bites of soup. When the certified dietary manager (CDM) observed the tray she stated,"Well, he did not eat very good. He is like that sometimes." Progress notes related to to R69's nutritional status were as noted: (1) A dietary note dated 5/3/16, at 6:16 a.m. identified R69 as an 88 yr old male with diagnoses as: HTN (hypertension), KD (kidney disease) and CHF (congestive heart failure). It was identified that R69 was administered Lasix (diuretic) medication due to diagnosis of edema and was at risk for dehydration. R69's diet was documented as No Added Salt (NAS) diet. R69 was independent with eating and intake greater than 75% of meals R69 had upper dentures and own teeth on lower jaw. No chewing nor swallowing problems documented. His weight and height were recorded as 230 lbs and 70 inches (5' 10"). (2) A dietary note dated 6/7/16, at 6:36 a.m. identified R69 with the following diagnoses: falls, advanced dementia, Stage III KD (kidney disease). Medications reviewed on physician's orders and included Lasix (diuretic) due to diagnosis of edema and at risk for dehydration.	F 325	Improvement Meeting for one full year.	

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F 325	Continued From page 21 R69 was identified as independent with eating and intake usually consuming greater than 75% of his food. No chewing or swallowing problems; weight documented as 223 lbs. and weight within usual range. The note also identified R69 was at risk due to diagnoses with need for NAS diet, due to multiple meds, due to body weight (BW) and BMI high and due to abnormal labs. The note identified staff to monitor intake, weights and hydration per policy/MD order; notify CDM, RD as needed. (3) A quarterly assessment/dietary note dated 7/12/16, at 11:11 a.m. identified R69's weight at 227 lbs., provided a NAS diet related to heart failure, consumed 75-100% of meals served and that R69 would try to eat his wife's food, who sat with him at the dining room table. The note also identified that R69 would refuse to eat at times and would want to go back to room. There were no chewing or swallowing problems identified. and the care plan was reviewed with no changes in goals or approaches. The medical record lacked any further documentation related to dietary status/weight loss other than weight recordings. R69's care plan dated 7/1/16, identified R69 could eat fine and was able to feed himself. The care plan interventions included: (1) Will continue to feed himself with set up daily. (2) Provide with the assistive eating devices/table and describe food and location on plate if needed. (3) Place things on the table that help distinguish items and tell him where things are if needed. (4) Take assisted devices on food-related activity outings, but respect decisions if he declined to	F 325		

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F 325	Continued From page 22 use them. (5) Check to see how R69 was doing when eating. If not eating/drinking something, ask what resident would like. Offer the same food in a different textures: offer thicker fluids (such as nectars) or thinner fluids (such as water). Observe for signs and symptoms of choking or swallowing difficulties and treat immediately. (6) Offer/provide me with nutritional supplements as needed. (7) Remind to sit upright for 30 minutes before and after meals to decrease the risk of aspiration. (8) Arrange for a Speech Therapist. They may have some helpful suggestions. When interviewed on 9/14/16, at 11:22 a.m. the certified dietary manager (CDM) was questioned about R69's recorded weight loss of 27 lbs since 7/1/16. The CDM indicated she was unaware of the weight loss and questioned whether the weight recorded was wrong. The CDM stated R69's weight loss might have been related to some dental work completed recently and/or related to the administration of Lasix (diuretic). The CDM stated that ongoing weights had been monitored but she had not identified R69's weight loss as a concern. She also stated the weight loss could have been related to R69's new wheelchair. The CDM further identified the registered dietician (RD) had consulted at the facility on 8/4/16 and 9/13/16 and verified that R69 had not been listed for RD review related to any weight loss. When interviewed on 9/14/16, at 11:27 a.m. registered nurse (RN)-C stated she was unaware of the weight loss and had not been notified. RN-C stated she would not have identified the weight loss until the next quarterly assessment	F 325		

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	245423	A. BUILDING _____ B. WING _____	09/15/2016

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F 325	Continued From page 23 was conducted and she would expect to be notified. The medical record lacked any evidence of the physician, registered dietician or nursing staff evaluated and/or put interventions in place related to the weight loss. When interviewed on 9/14/16, at 11:59 a.m. the director of nursing (DON) verified nursing staff should have reported/responded to the weight loss and verified the RD should also have been been notified of the weight loss. The DON stated she was unaware of the weight loss. On 9/14/16, at 12:05 p.m. the RD was contacted via phone. The RD was unaware of R69's weight loss and stated she did not recall reviewing R69's record when she was at the facility on 8/4/16 and 9/13/16. The RD stated she would expect the staff make her aware of significant weight loss but would not comment any further as she did not have R69's medical record to review. During interview with registered nurse (RN)-A on 9/14/16 at 1:46 p.m. RN-A stated she would expect to be notified if any resident sustained a significant weight loss. RN-A indicated she would proceed to request staff reweigh the resident for accuracy and look for non-health related conditions for the significant change in weight. The facility policy "Nutrition (Impaired) Unplanned Weight Loss-Clinical Protocol", revised September 2012 identified the following process for weight loss identification: Assessment and Recognition: 1. The nursing staff will monitor and document the weight and dietary intake of residents in a	F 325		

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F 325	Continued From page 24 format which permits readily available comparisons over time. 2. As part of the initial assessment, the staff and physician will define the individual's current nutritional status (weight, food/fluid intake, and pertinent laboratory values) and identify individuals with anorexia, recent weight loss and significant risk for impaired nutrition; for example, high risk residents with acute symptoms such as vomiting, diarrhea, fever or infection, or those taking medications that may be causing or increasing the risk of anorexia or weight loss. 3. The threshold for significant unplanned and undesired weight loss will be based on the following criteria: a. 1 month-5% weight loss is significant, greater than 5% is severe. b. 3 months-7.5 % weight loss is significant, greater than 7.5% is severe. c. 6 months-10 % weight loss is significant, greater than 10% is severe. Cause Identification: 1. The physician will review possible causes of anorexia or weight loss with the nursing staff and/or dietician before ordering interventions. a. The dietician will estimate calorie, nutrient and fluid needs and, with physician, will identify whether the resident's current intake is adequate to meet their nutritional needs. b. For individuals with recent or rapid weight loss (for example, more than a pound a day) the staff and physician should consider possible fluid and electrolyte imbalance as a cause, Fluid deficits can result in rapid weight loss. 2. The physician, with help of the multidisciplinary team, will identify conditions and medications that may be causing anorexia, weight loss, or increasing the risk of weight loss,	F 325		

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F 325	Continued From page 25 For example: a. Cognitive or functional decline. b. Chewing or swallowing abnormalities. c. Pain d. Medication-related adverse consequences. e. Environmental factors. f. Increased need for calories and/or protein. g. Poor digestion or absorption. h. Fluid and nutrient loss; and/or i. Inadequate availability of food or fluids.	F 325		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal 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 legal 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 legal 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	F 334		10/25/16

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F 334	Continued From page 26 contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal 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 legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal 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. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.	F 334		

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F 334	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement a policy and procedure related to the pneumococcal conjugate vaccine (PCV13) according to recommendations by the Centers for Disease Control (CDC) for 4 of 5 residents (R69, R80, R83 and R97) whose vaccination histories were reviewed. Findings include: R69's Immunization Record dated 4/12/16, indicated the 88 year old resident received the Pneumovax on 12/3/2008. There was no evidence he had been offered the PCV13 vaccine since his admission to the facility 4/12/16. R80's Immunization Record dated 6/17/16, indicated the 75 year old resident received the Pneumovax on 3/15/2006. There was no evidence she had been offered the PCV13 vaccine since her admission to the facility 6/17/16. R83's Immunization Record dated 3/29/16, indicated the 95 year old resident received the Pneumovax on 5/6/2004. There was no evidence she had been offered the PCV13 vaccine since her admission to the facility 3/29/16. R97's Immunization Record dated 3/16/16, indicated the 86 year old resident received the Pneumovax but the date was unknown. There was no evidence she had been offered the PCV13 vaccine since her admission to the facility 3/16/16. The CDC recommendations indicated, "Adults 65	F 334	This plan and response to MCS-2567 regarding Tag F 334, is written solely to maintain certification in the Medicare and Medical Assistance programs. We wish to preserve our right to dispute these findings in their entirely should any remedies be imposed. Chosen Valley Care Center will ensure that Influenza and Pneumococcal Immunizations are offered and documented for all residents according to facility policy. Chosen Valley Care Center□s Pneumococcal Vaccine Policy has been reviewed and updated. The Immunization Record for R69 was reviewed and he received the PCV13 vaccination as prescribed by physician on October 10, 2016. The Immunization Record for R80 was reviewed and she received the PCV13 vaccination as prescribed by physician on October 10, 2016. The Immunization Record for R83 was reviewed and physician stated that she did not need PCV13 because her immunization record was already up to date. The Immunization Record for R97 was reviewed and physician stated that she did not need PCV13 because her	

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F 334	Continued From page 28 years of age or older who have not previously received PCV13 and who have previously received one or more doses of PPSV23 [pneumococcal polysaccharide vaccine 23] should receive a dose of PCV13. The dose of PCV13 should be administered at least one year after the most recent PPSV23 dose." On 9/14/16, at 2:20 p.m. the director of nursing (DON) stated the new guidelines for updating pneumococcal vaccines had not been implemented in the facility. The DON verified an updated PCV13 vaccine had not been administered or offered and the facility policy had not been updated. The facility's policy and procedure for Pneumovax vaccines revised 6/15/14, did not include the new guidelines for the PCV13 vaccine.	F 334	immunization record was already up to date. All residents who reside at Chosen Valley Care Center have the potential to be affected by this deficient practice. All residents immunization records were obtained and will be reviewed by the residents physician or nurse practitioner and they will determine if the resident needs any vaccinations to be administered to bring their immunization records up to date. All staff will be in-serviced on October 20th, 21st, and 24th, 2016 on our revised Pneumococcal Vaccination Policy and the importance of offering and administering the vaccines to our residents. Influenza/PCV13 Audit will be completed by the Director of Nursing or her designee weekly for four weeks and then quarterly audits will be completed and presented at the Quality Improvement Meeting for one full year.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -	F 441		10/25/16

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F 441	Continued From page 29 (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to properly disinfect multi-use resident equipment between use for 3 of 5 residents (R73, R28, R80) observed to receive blood glucose monitoring. Findings include: During observation of the morning medication	F 441	This plan and response to MCS-2567 regarding Tag F 441, is written solely to maintain certification in the Medicare and Medical Assistance programs. We wish to preserve our right to dispute these findings in their entirely should any remedies be imposed. Chosen Valley Care Center ensures that	

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F 441	Continued From page 30 administration on 9/14/16, at 6:15 a.m. trained medication assistant (TMA)-B utilized a universal blood glucometer to monitor blood glucose levels. At 6:17 a.m. TMA-B entered R73's room with a small tray containing a blood glucometer, a cotton ball, lancet, and gloves. TMA-B informed R73 of the procedure to check the blood glucose level and then proceeded to perform the test. Upon completion of the test, TMA-B returned the glucometer equipment to the medication cart and placed it into a plastic tub/bin located on top of the medication cart. The tub contained lancets, alcohol wipes, cotton balls and glucose strips. At 6:22 a.m. TMA-B again was observed setting up the tray, placing the same glucometer utilized for R73, a cotton ball, lancet, gloves and a test strip onto the tray. TMA-B entered R28's room and conducted a blood glucose level test with the same multi-use glucometer used to check R73's blood glucose level. Upon completion of the blood glucose check with R28, TMA-B returned the multi-use glucometer to the medication cart and placed it into the bin containing the other glucose testing supplies. At 6:29 a.m. TMA-B was observed to set up glucometer supplies once again at the med cart and place the supplies on a small tray and carry them into R80's room. TMA-B checked R80's blood glucose levels utilizing the same glucometer she had utilized for R28 and R73. There was no observation of sanitization of the multi-use blood glucometer equipment prior to R28 and F80's blood glucose level checks. When interviewed on 9/14/16, at 6:35 a.m. TMA-B was questioned about multi-use glucometer cleaning between residents. TMA-B stated she was aware the glucometer needed to be sanitized between residents and verified she	F 441	we maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infections. R73, R8, and R80 clinical records were reviewed on September 14, 2016 for infection control purposes to ensure each resident was without infections at the time this practice was observed. No infections were noted. TMA-B was re-educated immediately on the proper way to disinfect the glucometer on September 14, 2016. All residents have the potential to be affected by this deficient practice as it relates to infection control. A facility wide audit was completed on October 5, 2016 and fifteen residents who have orders to monitor their blood sugars have the potential to be affected. All TMA□s who utilize the glucometer have been observed to ensure they are properly disinfecting the glucometer. All staff will be in-serviced on October 20th, 21st, and 24th, 2016 on our Blood Glucose Monitoring Policy which includes the proper way to disinfect the glucometers. Glucometer Cleaning Audit will be completed by the Director of Nursing or her designee weekly for four weeks and then quarterly audits will be completed	

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F 441	Continued From page 31 should have wiped the equipment between resident use. TMA-B pointed to the alcohol wipes on the cart containing the glucometer supplies, indicating she would utilize them to cleanse the glucometer. When specifically questioned whether she would utilize the alcohol wipes to disinfect, TMA-B responded "yes". TMA-B further clarified she was unaware the multi-use glucometer required different sanitization. When interviewed on 9/15/16, at 11:00 a.m. the director of nursing (DON) verified staff should wipe the multi-use glucometer equipment between resident use with the Sani-wipes which have bleach. When the policy for cleaning the reusable equipment was requested, the following was provided on 9/15/16, at 11:30 a.m. by the DON: "Disinfecting Reusable Equipment and Environmental Surfaces", undated, identified the following: Equipment: (a) After using reusable equipment it must be cleaned and returned to the place it is stored. Glucometer's must be cleaned after each use using the manufacturers instructions. At this time, the DON verified the manufacturers instructions for cleaning the glucometer included using a 1:10 bleach solution or super Sani-wipes. The DON stated the facility utilized the Sani-wipes versus bleach solution.	F 441	and presented at the Quality Improvement Meeting for one full year.	

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	245423	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/21/2016**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey dated 9/21/2016, Chosen Valley Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or Or by email to: Marian.Whitney@state.mn.us or Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/13/2016

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 prevent a reoccurrence of the deficiency. Chosen Valley Care Center is a 1-story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1975 and was determined to be of Type V(111) construction. In 1998, an addition was constructed and was determined to be of Type V(111) construction. In 2001, an addition was constructed and was determined to be of Type II(000) construction. In 2002, a canopy was constructed and was determined to be of Type V(111) construction. The construction type was changed after review of the architectural drawings that are on hand for the facility. Because the original building and the 3 addition are of the same type of construction and meet the construction type allowed for existing buildings, The facility will be surveyed as a Type V(111) building. The building is fully sprinkled. The facility has a fire alarm system with full corridor smoke detection and that is monitored for automatic fire department notification. The facility has a capacity of 78 beds and had a census of 72 at the time of the survey.	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is	K 018		10/25/16

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

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K 018	Continued From page 2 no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 On facility tour between 09:00 AM and 01:00 PM on 9/21/2016, based on observation and interview revealed that the findings include: 1.Corridor door do not latch in the close position when tested in room 205. 2. Rooms A107 and A110 has doors that do not close as beds are blocking door from closing.	K 018	The Director of Environmental Services met with Bowman Door and Hardware Company on October 5, 2016 to inspect the warped door in room E-205. A new door is required and Bowman Door and Hardware Company has agreed to furnish and install a new door ensuring that it will latch properly and have the appropriate fire rating. They have agreed to install the new door on or before October 25, 2016. On September 22, 2016 The Director of Environmental Services inspected all rooms to ensure that the doors to the resident rooms latch appropriately. The doors to rooms A107 and A110 did not latch appropriately and upon further investigation it was noted that the beds in rooms A107 and A110 were preventing the door from closing so the wall protection bar was removed from the beds and his allows the bed to be positioned and the door to operate and latch appropriately. Door Latch Audit has been developed; our safety committee will check one wing of doors monthly and report to our Quality Improvement Meeting for one full year.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/21/2016**

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K 018	Continued From page 3 This deficient practice could affect the safety of the (13) residents within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 018		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 On facility tour between 09:00 AM and 01:00 PM on 9/21/2016, based on observation and interview revealed that equipment room 115 has missing ceiling tile and penetrations around wiring and sprinkler head large than a 1/4" of an inch. This deficient practice could affect the safety of the (6) residents within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 062	On October 6, 2016 the Director of Environmental Services repaired the ceiling tiles in room 115. Ceiling Tile Audit has been developed; our safety committee will check ceiling tiles as part of our monthly inspection, and report to our Quality Improvement Meeting for one full year.	10/25/16

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
October, 2016

Mr. Craig Backen, Administrator
Chosen Valley Care Center
1102 Liberty Street Southeast
Chatfield, MN 55923

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5423026 and Complaint Numbers H5423015 and H5423016

Dear Mr. Backen:

The above facility was surveyed on September 12, 2016 through September 15, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint numbers H5423015 and H5423016 that were found to be unsubstantiated. 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 that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted 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 after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Gary Nederhoff, Unit Supervisor at (507) 206-2731.

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00750	A. BUILDING: _____ B. WING _____	09/15/2016

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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: 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 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. On September 12-15, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. In addition, a complaint investigation for H5423016 and H5423015 and was unsubstantiated. 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. PLEASE DISREGARD THE HEADING OF THE	2 000		

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2 000	Continued From page 2 FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment;	2 265		10/25/16

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2 265	Continued From page 3 D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on observation, document review and staff interview the facility failed to notify the physician of the significant weight loss experienced for 1 of 3 residents (R69) reviewed for nutrition. Findings include: R69 was admitted on 4/12/16, with diagnoses that included GERD (gastroesophageal reflux disease), peptic ulcer, dementia, stage 3 kidney disease, anxiety and depression. R69's quarterly Minimum Data Set (MDS) assessment identified R69 with a Brief Interview for Mental Status (BIMS) score of 4 indicating severe cognitive impairment and identified he was independent with eating with only set up assistance needed. The nutrition section of the MDS identified R69 with a weight of 227 pounds and indicated no nutritional problems. During review of R69's medical record, height and weight tracking R69 was noted to have sustained a significant weight loss since admission and more specifically within the past two months (7/1/16-9/6/16). R69's weight record (most current) indicated the following weights: 9/6/16-199.8 pounds (lbs) which identified R69 with a 10% weight loss since admission. 8/1/16-214.0 lbs which indicated a 5% weight loss since 7/1/2016. 7/1/16-227.0 lbs	2 265	Corrected	

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2 265	Continued From page 4 6/2/16-223.0 lbs 5/10/16-224.0 lbs 5/1/16- 230.0 lbs 4/14/16-224.0 lbs 4/13/16-225.0 lbs During observation on 9/13/16, at 5:09 p.m. R69 was seated at the dining room table in his wheelchair. R69 was served a lemon bar, 1 buttered bread slice, boiled potatoes and spinach. R69 was observed to consume less than 1/2 of the evening meal. R69 was noted to sit at the table for a long time period just looking around the dining room. During observation of the brunch meal on 9/14/16, at 12:00 p.m. R69 was served the following food items: 2 strips of bacon, 1 buttered toast slice, hash brown triangle, soup and half a turkey sandwich. At 12:45 p.m. when R69 left the dining room it was noted he consumed 1/4 piece of bacon, 1/2 piece of toast, 1/2 hash brown triangle, none of the turkey sandwich and had consumed approximately 2 bites of soup. When the certified dietary manager (CDM) observed the tray she stated,"Well, he did not eat very good. He is like that sometimes." Progress notes related to to R69's nutritional status were as noted: (1) A dietary note dated 5/3/16, at 6:16 a.m. identified R69 as an 88 yr old male with diagnoses as: HTN (hypertension), KD (kidney disease) and CHF (congestive heart failure). It was identified that R69 was administered Lasix (diuretic) medication due to diagnosis of edema and was at risk for dehydration. R69's diet was documented as No Added Salt (NAS) diet. R69 was independent with eating and intake greater than 75% of meals R69 had upper dentures and	2 265		

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2 265	Continued From page 5 own teeth on lower jaw. No chewing nor swallowing problems documented. His weight and height were recorded as 230 lbs and 70 inches (5' 10"). (2) A dietary note dated 6/7/16, at 6:36 a.m. identified R69 with the following diagnoses: falls, advanced dementia, Stage III KD (kidney disease). Medications reviewed on physician's orders included Lasix (diuretic) due to diagnosis of edema and at risk for dehydration. R69 was identified as independent with eating and intake usually consuming greater than 75% of his food. No chewing or swallowing problems; weight documented as 223 lbs. and weight within usual range. The note also identified R69 was at risk due to diagnoses with need for NAS diet, due to multiple meds, due to body weight (BW) and BMI high and due to abnormal labs. The note identified staff to monitor intake, weights and hydration per policy/MD order; notify CDM, RD as needed. (3) A quarterly assessment/dietary note dated 7/12/16, at 11:11 a.m. identified R69's weight at 227 lbs., provided a NAS diet related to heart failure, consumed 75-100% of meals served and that R69 would try to eat his wife's food, who sat with him at the dining room table. The note also identified that R69 would refuse to eat at times and would want to go back to room. There were no chewing or swallowing problems identified and the care plan was reviewed with no changes in goals or approaches. The medical record lacked any further documentation related to dietary status/weight loss other than weight recordings. R69 experienced a 27 lb. weight loss since the recorded weight of 227 lbs on 7/1/16 and 198.9	2 265		

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2 265	Continued From page 6 lbs on 9/6/16. The medical record lacked any evidence of physician notification of the significant weight loss. When interviewed on 9/14/16, at 11:22 a.m. the certified dietary manager (CDM) was questioned about R69's recorded weight loss of 27 lbs since 7/1/16. The CDM indicated she was unaware of the weight loss and questioned whether the weight recorded was wrong. The CDM stated R69's weight loss might have been related to some dental work completed recently and/or related to the administration of Lasix (diuretic). The CDM stated that ongoing weights had been monitored but she had not identified R69's weight loss as a concern. She also stated the weight loss could have been related to R69's new wheelchair. The CDM further identified the registered dietician (RD) had consulted at the facility on 8/4/16 and 9/13/16 and verified that R69 had not been listed for RD review related to any weight loss. When interviewed on 9/14/16, at 11:27 a.m. registered nurse (RN)-C stated she was unaware of the weight loss and had not been notified. RN-C stated she would not have identified the weight loss until the next quarterly assessment was conducted and she would expect to be notified. When interviewed on 9/14/16, at 11:59 a.m. the director of nursing (DON) verified nursing staff should have reported/responded to the weight loss to the physician and verified the RD should also have been been notified of the weight loss. The DON stated she was unaware of the weight loss. On 9/14/16, at 12:05 p.m. the RD was contacted	2 265		

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2 265	Continued From page 7 via phone. The RD was unaware of R69's weight loss and stated she did not recall reviewing R69's record when she was at the facility on 8/4/16 and 9/13/16. The RD stated she would expect the staff make her aware of significant weight loss but would not comment any further as she did not have R69's medical record to review. During interview with registered nurse (RN)-A on 9/14/16 at 1:46 p.m. RN-A stated she would expect to be notified if any resident sustained a significant weight loss. RN-A indicated she would proceed to request staff reweigh the resident for accuracy and look for non-health related conditions for the significant change in weight. The facility policy "Change in Resident's Condition or Status", revised September 2013, identified in the Policy Statement; The facility shall promptly notify the resident, his or her attending physician, and representative of changes in the resident's medical/mental condition and/or status. Policy Interpretation and Implementation: (1) The nurse supervisor/charge nurse will notify the resident's attending physician or on-call physician when there has been: a. An accident or incident involving the resident b. A discovery of injuries of unknown origin. c. A reaction to medication d. A significant change in the resident's physical/emotional/mental condition. e. A need to alter the resident's medical treatment significantly. f. Refusal of treatment or medications g. A need to transfer the resident to a hospital or treatment center. h. A discharge without proper medical authority. i. Instructions to notify the physician of changes in the resident's condition.	2 265		

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2 265	Continued From page 8 (2) A "Significant change" of condition is a decline or improvement in the resident's health status that: a. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions. b. Impacts more than one area of the residents health status. c. Requires interdisciplinary review and/or revision to the care plan; and d. Ultimately is based on the judgement of the clinical staff and the guidelines outlined in the Resident Assessment Instrument [RAI]. SUGGESTED METHOD OF CORRECTION: The director of nursing could conduct an inservice to educate nursing staff when to notify the physician and family of a change in condition. An audit could be conducted to ensure nursing staff notify the physician in a timely manner of significant changes in condition. The results of the audits could be reviewed during the quality assurance committee meetings. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		
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:	2 565		10/25/16

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2 565	Continued From page 9 Based on observation, interview and document review the facility failed to implement the plan of care to reduce the risk of injury during falls for 1 of 4 residents (R69) reviewed for falls. Findings include: R69 was admitted on 4/12/16. The quarterly Minimum Data Set (MDS) assessment dated 7/10/16, identified R69 with a Brief Interview for Mental Status (BIMS) score of 4 indicating a severe cognition deficit. The MDS further identified R69 required limited assistance of one staff with toileting and transfers. Also, the MDS identified R69 had sustained 2 or more falls since his admission and had sustained minor injuries with 2 or more falls. Fourteen falls were documented in progress notes from 4/12/16 until 9/13/16 which identified that R69 attempted self transfers and/or self-cares repeatedly since admission. On 9/13/16 at 3:55 p.m. a progress note identified R69 was found by staff sitting on his floor, with chair alarm sounding, between his wheelchair and recliner. The note identified R69 was attempting to self transfer without assistance. The interdisciplinary team (IDT) progress note dated 9/14/16, at 8:34 a.m. identified current fall interventions to include: (1) gripper socks at bedtime and when wearing shoes; (2) hip protestors at all times; (3) door/curtain open as able for increased supervision; (4) every 1 hour checks while in room; (5) offer toileting (every 30 minutes for increased confusion); (6) morning cares/dressing assistance at 5:00 a.m.-5:30 a.m.; (7) offer evening cares right after supper; (8) personal safety alarm at all times; (9) keep walker at bedside and (10) place dicem above and below wheelchair cushion. These were identified on the	2 565	Corrected	

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	00750	A. BUILDING: _____ B. WING _____	09/15/2016

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2 565	Continued From page 10 care plan dated 7/21/16 as R69 had impaired mobility related to increased weakness and impaired balance secondary to dementia and history of trans-ischemic attacks (TIA's) and required assistance ambulation and positioning and R69 utilized a wheelchair or walker for mobility. During observation of a morning cares on 9/13/16, at 5:41 p.m. NA-A entered R69's room to answer the call light and noted R69 attempting to enter the bathroom. NA-A was observed to remove R69 away from the bathroom door in his wheelchair and leave the room. After staff left the room, R69 immediately wheeled himself back into the bathroom and attempted independent toileting. R69 attempted to stand which activated the chair alarm. At 5:45 p.m. registered nurse (RN)-A responded to the activated alarm sound and entered the room and to assist R69 to pivot onto the toilet. It was observed that when R69 stood in front of the toilet, he was shaky and unable to pivot self and sit on toilet without assistance. When interviewed on 9/13/16, at 5:50 p.m. NA-A stated she had to leave the room to locate staff to assist R69 to the bathroom. NA-A stated she was aware R69 was at risk for falling and required assistance to toilet. During this observation R69 did not have his hip protectors attached as directed by his care plan. During a subsequent interview on 9/13/16, at 6:33 p.m. RN-A stated NA-A should have stayed with R69 and called someone to help her. RN-A stated, "He [R69] is a huge fall risk". RN-A stated staff definitely needed more training as it was not acceptable to leave R69 alone when staff are aware he will attempt to self transfer.	2 565		

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2 565	Continued From page 11 When interviewed on 9/13/16, at 6:50 p.m. NA-B verified when she undressed R69 for bedtime cares he did not have his hip protectors on and further indicated she was unaware whether he had worn them during the entire shift. NA-B further stated that R69 would often refuse to put the hip protectors on. During interview with RN-C on 9/15/16 at 8:56 a.m. she stated the care plan had just been changed to reflect that R69 often would refuse the use of the hip protectors. RN-C verified the care plan interventions had indicated that R69 should wear hip protectors at all times. No policy related to Fall intervention was received from facility staff. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and	2 830		10/25/16

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2 830	Continued From page 12 plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide care in a manner to reduce the risk of fall and injury for 1 of 4 residents (R69) reviewed for accidents. Findings include: R69 was admitted on 4/12/16. The quarterly Minimum Data Set (MDS) assessment dated 7/10/16, identified R69 with a Brief Interview for Mental Status (BIMS) score of 4 indicating a severe cognition deficit. The MDS further identified R69 required limited assistance of one staff with toileting and transfers. Also, the MDS identified R69 had sustained 2 or more falls since his admission and had sustained minor injuries with 2 or more falls. Multiple falls were documented and progress notes identified that R69 attempted self transfers and/or self-cares repeatedly as noted: (1) On 9/13/16, at 3:55 p.m. R69 found by staff sitting on his floor, with chair alarm sounding, between his wheelchair and recliner; attempting to self transfer without assistance. (2) On 8/30/16, at 6:55 a.m. R69 was seated on the patio outside the front door and was attempting to wheel himself back in the facility when his	2 830	Corrected	

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2 830	Continued From page 13 wheelchair cushion slipped out of his wheelchair and R69 slid out with cushion onto the patio. No injury noted. (3) On 8/19/16, at 6:00 p.m. R69's bed alarm was heard sounding and when staff entered room R69 was observed sitting on the floor in his room; appeared to be trying to get ready for bed. (4) On 8/3/16, at 4:00 a.m. R69's alarm sounded, staff responded and R69 was observed sitting on the floor in the middle of his room; attempted to self ambulate to the bathroom by himself. (5) On 8/2/16, at 10:30 a.m. a nursing assistant (NA) was assisting R69 to the toilet with the use of a gait belt, R69 attempted to sit before reaching the toilet and was lowered to the floor. (6) On 7/31/16, at 4:39 a.m. R69's alarm was sounding, staff arrived at the room R69 was witnessed to fall backwards and land on floor beside bed; received abrasions which required treatment. (7) On 7/29/16, at 11:30 R69 was walking from his bed to the bathroom with use of walker without assistance and fell backwards into his bedside table; received two skin tears -required nursing treatment. (8) On 7/29/16, at 12:15 p.m. R69 fell again, toileted without assistance. (9) On 7/13/16, at 6:28 p.m. R29 was found on the floor by his wife after returning from the evening meal. (10) On 7/5/16, at 9:10 a.m. R69 was was found lying on his back in the middle of his room with his pants around his ankles; sustained a laceration to his left wrist. (11) On 6/22/16, at 2:18 p.m. R69 was found on the floor in his bathroom; stated he was going to the bathroom. (12) On 5/23/16, at 8:49 a.m. R69 was found on the floor in his room in front of his recliner.(13) On 5/16/16, at 9:30 a.m. R69 was found sitting on the	2 830		

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2 830	Continued From page 14 floor in his room yelling for help. (14) On 4/12/16 at 5:19 p.m. R69 was found seated on the floor in his bathroom. During observation of a morning cares on 9/13/16, at 5:41 p.m. NA-A entered R69's room to answer the call light and noted R69 attempting to enter the bathroom. NA-A was observed to remove R69 away from the bathroom door in his wheelchair and leave the room. After staff left the room, R69 immediately wheeled himself back into the bathroom and attempted independent toileting. R69 attempted to stand which activated the chair alarm. At 5:45 p.m. registered nurse (RN)-A responded to the activated alarm sound and entered the room and to assist R69 to pivot onto the toilet. It was observed that when R69 stood in front of the toilet, he was shaky and unable to pivot self and sit on toilet without assistance. When interviewed on 9/13/16, at 5:50 p.m. NA-A stated she had to leave the room to locate staff to assist R69 to the bathroom. NA-A stated she was aware R69 was at risk for falling and required assistance to toilet. During this observation R69 did not have his hip protectors attached as directed by his care plan. During a subsequent interview on 9/13/16, at 6:33 p.m. RN-A stated NA-A should have stayed with R69 and called someone to help her. RN-A stated, "He [R69] is a huge fall risk". RN-A stated staff definitely needed more training as it was not acceptable to leave R69 alone when staff are aware he will attempt to self transfer. When interviewed on 9/13/16, at 6:50 p.m. NA-B verified when she undressed R69 for bedtime cares he did not have his hip protectors on and	2 830		

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2 830	Continued From page 15 stated she was not aware whether he had them on the entire shift. NA-B further stated that R69 would often refuse to put the hip protectors on. R69's care plan dated 7/21/16, identified R69 had impaired mobility related to increased weakness and impaired balance secondary to dementia and history of trans-ischemic attacks (TIA's) and required assistance ambulation and positioning and R69 utilized a wheelchair or walker for mobility. The following interventions to reduce fall risk included: (1) assist of one staff to walk with walker; (2) one staff assistance to put gripper socks on at bedtime; (3) call light is always within reach; (4) check every 1 hour in room to ensure needs have been met and offer toileting; (5) if refusal of care have another staff attempt to assist; (6) offer evening care right after supper to avoid attempt to independently perform cares and risk of falling; (7) monitor for signs and symptoms of unsteady gait, unsteady balance, poor posture, leaning, tilting, dizziness, fatigue, poor/double vision; (8) teach and remind to rise slowly from sitting or laying positions to avoid dizziness; (9) conduct fall assessment at least quarterly, checking ambulation, balance blood pressure, bowel and bladder issues, coordination, diagnoses, endurance, history of fall, mental status, medications and vision; and (10) hip protectors on at all times. The interdisciplinary team (IDT) progress note dated 9/14/16, at 8:34 a.m. identified current fall interventions to include: (1) gripper socks at bedtime and when wearing shoes; (2) hip protestors at all times; (3) door/curtain open as able for increased supervision; (4) every 1 hour checks while in room; (5) offer toileting (every 30 minutes for increased confusion); (6) morning cares/dressing assistance at 5:00 a.m.-5:30 a.m.;	2 830		

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2 830	Continued From page 16 (7) offer evening cares right after supper; (8) personal safety alarm at all times; (9) keep walker at bedside and (1) place dicem above and below wheelchair cushion. During interview with RN-C on 9/15/16 at 8:56 a.m. she stated the care plan had just been changed to reflect that R69 often would refuse the use of the hip protectors. RN-C verified the care plan interventions had indicated that R69 should wear hip protectors at all times. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to supervision and preventing an accident. The DON or designee, could provide training for all nursing staff related to the accident prevention. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and	2 900		10/25/16

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2 900	Continued From page 17 B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively reassess and implement timely interventions for 1 of 1 resident (R9) reviewed who developed a Stage III pressure ulcer located on the ankle. Findings include: A significant change Minimum Data Set (MDS) assessment dated 1/10/16, identified R9 as being at risk for pressure ulcers (PU) but had no (0) pressure ulcers at this time. The Care Area Assessment (CAA) dated 1/12/16, identified R9 at mild risk for PU secondary to requiring extensive assistance with bed mobility (2 staff) and frequently incontinent of bowel and bladder. The CAA identified no open areas (skin) nor areas of concern and the interventions included the use of pressure reducing cushion in w/c (wheelchair), lip mattress on bed, turn and reposition every 2 hours. However, on the quarterly MDS assessment dated 6/26/16, a stage II pressure ulcer was identified. During observation on 9/15/2016, at 8:31 a.m. R9 was noted lying in bed on her back. R9 had gripper socks on but no heel protectors and heels/feet were not floated as pillow was under her knees. At 8:33 a.m. licensed practical nurse (LPN)- A verified R9's heels/feet were not floated and R9 did not have heel protectors on. No heel	2 900	Corrected	

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2 900	Continued From page 18 protectors were found in R9's room. Review of the care plan dated 6/3/16, identified interventions that included: (1) staff were to offload R9's heels and ankles when in bed, (2) turn and reposition every two hours when in bed or chair and (3) give 4 ounces of Resource 2.0 (a calorie and protein dense drink appropriate for wound prevention and treatment programs) 4 times per day. The current care plan did not identify the current Stage III PU located on the right ankle nor had it been updated to reflect the use of the heel protector. Review of the Braden scale for predicting PU risk dated 6/23/16, did not identify the pressure ulcer. No further Braden scale assessments were conducted since 6/23/16 nor any other reassessments (e.g. tissue tolerance) related to the PU. Review of the Weekly Skin Charting was as noted: 4/16/16- bruise to right outer ankle measuring 0.6 by 0.6 centimeters (cm) and fluid filled. A note was sent to the physician. No new intervention implemented. 4/23/16- area to right outer ankle measures 0.6 cm by 0.6 cm and is cleansed with normal saline (NS) and covered with foam dressing. 4/30/16- PU to right outer ankle, area is dark, measured 0.3 by 0.3 cm, no drainage and covered with foam and changed every three days. 5/7/16- area to right ankle measures 1 cm by 1 cm, covered with foam. No changes in plan of care with increase in size from 0.3 to measurement of 1 cm. 5/14/16-scabbed area to right ankle measures 1 cm by 1 cm. 5/23/16- wound/scab area to outer right ankle measures 1 cm by 1 cm and covered with a foam pad. 5/29/16-continues to have scabbed area to right	2 900		

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2 900	Continued From page 19 ankle measuring 1 by 1 cm. 6/11/16-duoderm (colloid dressing) over right ankle (no measurements of ulcer). 7/9/16-continues to have open area to right outer ankle. 8/27/16-right ankle measured 0.5 by 0.5 cm. 9/3/16-right ankle ulcer continues and measured 0.3 by 0.4 by 0.1 cm. Stage III (a full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of the tissue loss. May include undermining and tunneling). Review of the Pressure Ulcer Weekly Flow Sheet is as follows for the right ankle: 6/4/16-0.8 cm by 0.8 cm, no depth, Stage II pressure ulcer (partial thickness skin loss involving epidermis and or dermis. Superficial and presents as abrasion, blister or shallow crater). Treatment: cleanse with normal saline (NS) apply Aquacel and cover with Duoderm every 3 days and as needed (prn). 6/19/16-0.5 cm by 0.4 cm, no depth, Stage II; No change in treatment. 6/25/16-0.7 by 0.5 cm, no depth, Stage II; No change in treatment. 7/2/16-0.8 by 0.9 cm, no depth, Stage II; No change in treatment. 7/16/16- 0.9 by 0.6 cm, no depth, Stage II; Change in treatment: NS, apply collagen gel, Aquacel and non-adhesive foam dressing every 3 days and prn. 7/23/16-0.8 by 0.8 cm by 0.1 cm depth, Stage III; No reassessment documented with change in PU from Stage II to Stage III nor change in treatment. 7/30/16-0.8 cm by 0.8 cm by 0.1 cm depth, Stage III; No change in treatment plan. 8/7/16-0.8 by 0.7 by 0.1 cm depth, Stage III; Treatment changed: Apply antibiotic ointment to	2 900		

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2 900	Continued From page 20 ulcer on right ankle, cover with Aquacel and Duoderm and change every 5 days and prn. 8/14/16-0.8 by 0.8 by 0.1 cm depth, Stage III; Same treatment. 8/20/16-0.5 by 0.5 cm by 0.1 cm depth, Stage III; Continue same treatment. 9/3/16- 0.3 by 0.4 by 0.1 cm depth, Stage III. 9/17/16-0.4 by 0.4 cm, no depth, healing, Stage III. When interviewed on 9/14/16, at 1:04 p.m. registered nurse (RN)-A verified that R9 was identified to be at risk for developing pressure ulcers and developed a Stage III pressure ulcer to the right ankle after admission to the facility. RN-A confirmed no further reassessments were conducted during the time when the pressure ulcer had deteriorated from a Stage II to Stage III. Although the treatments were changed, the plan of care did not reflect the current interventions required to prevent further deterioration and/or promote healing of the ankle PU. The undated facility policy titled, Pressure Ulcer Treatment indicated the following protocol for the care of an existing pressure ulcer: (9) Start Tissue Tolerance Evaluation and notify nurses on communication board; (10) Change care plan for resident to be repositioned every 1 hour while in bed and chair; (11) Pressure ulcer to monitored at minimum once daily; (12) Re-evaluate supportive surfaces and determine if new interventions are indicated; (13) Treatment to be re-evaluated at minimum every 14 days for effectiveness. If no improvement re-evaluate nutritional support/off-loading/redistribution devices and new treatment; and (14) If Pressure Ulcer progresses notify physician immediately and follow staging protocols.	2 900		

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2 900	Continued From page 21 SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a significant weight loss was identified and evaluated so the necessary interventions could be implemented for 1 of 3 resident (R69) reviewed for nutrition and experienced significant weight loss. Findings include:	2 965	Corrected	10/25/16

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2 965	Continued From page 22 R69 was admitted on 4//12/16, with diagnoses that included GERD, peptic ulcer, hypertension, dementia, stage 3 kidney disease, anxiety and depression. R69's quarterly Minimum Data Set (MDS) assessment identified R69 with a Brief Interview for Mental Status (BIMS) score of 4 indicating severe cognitive impairment and identified he was independent with eating with only set up assistance needed. The nutrition section of the MDS identified R69 with a weight of 227 pounds and indicated no nutritional problems. During review of R69's medical record, height and weight tracking R69 was noted to have sustained a significant weight loss since admission and more specifically within the past two months (7/1/16-9/6/16). R69's weight record indicated the following weights: 9/6/16-199.8 pounds (lbs) which identified R69 with a 10% weight loss since admission. 8/1/16-214.0 lbs which indicated a 5% weight loss since 7/1/2016. 7/1/16-227.0 lbs 6/2/16-223.0 lbs 5/10/16-224.0 lbs 5/1/16- 230.0 lbs 4/14/16-224.0 lbs 4/13/16-225 Lbs During observation on 9/13/16, at 5:09 p.m. R69 was seated at the dining room table in his wheelchair. R69 was served a lemon bar, 1 buttered bread slice, boiled potatoes and spinach. R69 was observed to consume less than 1/2 of the evening meal. R69 was noted to sit at the table for a long time period just looking around the dining room.	2 965		

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2 965	Continued From page 23 During observation of the brunch meal on 9/14/16, at 12:00 p.m. R69 was served the following food items: 2 strips of bacon, 1 buttered toast slice, hash brown triangle, soup and half a turkey sandwich. At 12:45 p.m. when R69 left the dining room it was noted he consumed 1/4 piece of bacon, 1/2 piece of toast, 1/2 hash brown triangle, none of the turkey sandwich and had consumed approximately 2 bites of soup. When the certified dietary manager (CDM) observed the tray she stated,"Well, he did not eat very good. He is like that sometimes." Progress notes related to to R69's nutritional status were as noted: (1) A dietary note dated 5/3/16, at 6:16 a.m. identified R69 as an 88 yr old male with diagnoses as: HTN (hypertension), KD (kidney disease) and CHF (congestive heart failure). It was identified that R69 was administered Lasix (diuretic) medication due to diagnosis of edema and was at risk for dehydration. R69's diet was documented as No Added Salt (NAS) diet. R69 was independent with eating and intake greater than 75% of meals R69 had upper dentures and own teeth on lower jaw. No chewing nor swallowing problems documented. His weight and height were recorded as 230 lbs and 70 inches (5' 10"). (2) A dietary note dated 6/7/16, at 6:36 a.m. identified R69 with the following diagnoses: falls, advanced dementia, Stage III KD (kidney disease). Medications reviewed on physician's orders and included Lasix (diuretic) due to diagnosis of edema and at risk for dehydration. R69 was identified as independent with eating and intake usually consuming greater than 75% of his food. No chewing or swallowing problems; weight documented as 223 lbs. and weight within	2 965		

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2 965	Continued From page 24 usual range. The note also identified R69 was at risk due to diagnoses with need for NAS diet, due to multiple meds, due to body weight (BW) and BMI high and due to abnormal labs. The note identified staff to monitor intake, weights and hydration per policy/MD order; notify CDM, RD as needed. (3) A quarterly assessment/dietary note dated 7/12/16, at 11:11 a.m. identified R69's weight at 227 lbs., provided a NAS diet related to heart failure, consumed 75-100% of meals served and that R69 would try to eat his wife's food, who sat with him at the dining room table. The note also identified that R69 would refuse to eat at times and would want to go back to room. There were no chewing or swallowing problems identified. and the care plan was reviewed with no changes in goals or approaches. The medical record lacked any further documentation related to dietary status/weight loss other than weight recordings. The medical record lacked any evidence of the physician, registered dietician or nursing staff evaluated and/or put any interventions in place related to the weight loss. R69's care plan dated 7/1/16, identified R69 could eat fine and was able to feed himself. The care plan interventions included: (1) Will continue to feed himself with set up daily. (2) Provide with the assistive eating devices/table and describe food and location on plate if needed. (3) Place things on the table that help distinguish items and tell him where things are if needed. (4) Take assisted devices on food-related activity outings, but respect decisions if he declined to use them.	2 965		

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2 965	Continued From page 25 (5) Check to see how R69 was doing when eating. If not eating/drinking something, ask what resident would like. Offer the same food in a different textures: offer thicker fluids (such as nectars) or thinner fluids (such as water). Observe for signs and symptoms of choking or swallowing difficulties and treat immediately. (6) Offer/provide me with nutritional supplements as needed. (7) Remind to sit upright for 30 minutes before and after meals to decrease the risk of aspiration. (8) Arrange for a Speech Therapist. They may have some helpful suggestions. When interviewed on 9/14/16, at 11:22 a.m. the certified dietary manager (CDM) was questioned about R69's recorded weight loss of 27 lbs since 7/1/16. The CDM indicated she was unaware of the weight loss and questioned whether the weight recorded was wrong. The CDM stated R69's weight loss might have been related to some dental work completed recently and/or related to the administration of Lasix (diuretic). The CDM stated that ongoing weights had been monitored but she had not identified R69's weight loss as a concern. She also stated the weight loss could have been related to R69's new wheelchair. The CDM further identified the registered dietician (RD) had consulted at the facility on 8/4/16 and 9/13/16 and verified that R69 had not been listed for RD review related to any weight loss. When interviewed on 9/14/16, at 11:27 a.m. registered nurse (RN)-C stated she was unaware of the weight loss and had not been notified. RN-C stated she would not have identified the weight loss until the next quarterly assessment was conducted and would expect to be notified.	2 965		

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2 965	Continued From page 26 When interviewed on 9/14/16, at 11:59 a.m. the director of nursing (DON) verified nursing staff should have reported/responded to the weight loss and verified the RD should also have been been notified of the weight loss. The DON stated she was unaware of the weight loss. On 9/14/16, at 12:05 p.m. the RD was contacted via phone. The RD was unaware of R69's weight loss and stated she did not recall reviewing R69's record when she was at the facility on 8/4/16 and 9/13/16. The RD stated she would expect the staff make her aware of significant weight loss but would not comment any further as she did not have R69's medical record to review. During interview with registered nurse (RN)-A on 9/14/16 at 1:46 p.m. RN-A stated she would expect to be notified if any resident sustained a significant weight loss. RN-A indicated she would proceed to request staff reweigh the resident for accuracy and look for non-health related conditions for the significant change in weight. The facility policy "Nutrition (Impaired) Unplanned Weight Loss-Clinical Protocol", revised September 2012 identified the following process for weight loss identification: Assessment and Recognition: 1. The nursing staff will monitor and document the weight and dietary intake of residents in a format which permits readily available comparisons over time. 2. As part of the initial assessment, the staff and physician will define the individual's current nutritional status (weight, food/fluid intake, and pertinent laboratory values) and identify individuals with anorexia, recent weight loss and significant risk for impaired nutrition; for example, high risk residents with acute symptoms such as	2 965		

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2 965	Continued From page 27 vomiting, diarrhea, fever or infection, or those taking medications that may be causing or increasing the risk of anorexia or weight loss. 3. The threshold for significant unplanned and undesired weight loss will be based on the following criteria: a. 1 month-5% weight loss is significant, greater than 5% is severe. b. 3 months-7.5 % weight loss is significant, greater than 7.5% is severe. c. 6 months-10 % weight loss is significant, greater than 10% is severe. Cause Identification: 1. The physician will review possible causes of anorexia or weight loss with the nursing staff and/or dietician before ordering interventions. a. The dietician will estimate calorie, nutrient and fluid needs and, with physician, will identify whether the resident's current intake is adequate to meet their nutritional needs. b. For individuals with recent or rapid weight loss (for example, more than a pound a day) the staff and physician should consider possible fluid and electrolyte imbalance as a cause, Fluid deficits can result in rapid weight loss. 2. The physician, with help of the multidisciplinary team, will identify conditions and medications that may be causing anorexia, weight loss, or increasing the risk of weight loss, For example: a. Cognitive or functional decline. b. Chewing or swallowing abnormalities. c. Pain d. Medication-related adverse consequences. e. Environmental factors. f. Increased need for calories and/or protein. g. Poor digestion or absorption. h. Fluid and nutrient loss; and/or i. Inadequate availability of food or fluids.	2 965		

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2 965	Continued From page 28 SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and dietary services could review and revise policies and procedures for proper monitoring of weight loss. Nursing and dietary staff could be educated as necessary to the importance of monitoring weights. The DON or designee, along with the dietary staff, could audit weight loss on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 965		
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 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	21390		10/25/16

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21390	Continued From page 29 disinfectants, antiseptics, gloves, and incontinence products; and l. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to properly disinfect multi-use resident equipment between use for 3 of 5 residents (R73, R28, R80) observed to receive blood glucose monitoring. Findings include: During observation of the morning medication administration on 9/14/16, at 6:15 a.m. trained medication assistant (TMA)-B utilized a universal blood glucometer to monitor blood glucose levels. At 6:17 a.m. TMA-B entered R73's room with a small tray containing a blood glucometer, a cotton ball, lancet, and gloves. TMA-B informed R73 of the procedure to check the blood glucose level and then proceeded to perform the test. Upon completion of the test, TMA-B returned the glucometer equipment to the medication cart and placed it into a plastic tub/bin located on top of the medication cart. The tub contained lancets, alcohol wipes, cotton balls and glucose strips. At 6:22 a.m. TMA-B again was observed setting up the tray, placing the same glucometer utilized for R73, a cotton ball, lancet, gloves and a test strip onto the tray. TMA-B entered R28's room and conducted a blood glucose level test with the same multi-use glucometer used to check R73's blood glucose level. Upon completion of the blood glucose check with R28, TMA-B returned the multi-use glucometer to the medication cart and placed it into the bin containing the other	21390	Corrected	

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21390	Continued From page 30 glucose testing supplies. At 6:29 a.m. TMA-B was observed to set up glucometer supplies once again at the med cart and place the supplies on a small tray and carry them into R80's room. TMA-B checked R80's blood glucose levels utilizing the same glucometer she had utilized for R28 and R73. There was no observation of sanitization of the multi-use blood glucometer equipment prior to R28 and F80's blood glucose level checks. When interviewed on 9/14/16, at 6:35 a.m. TMA-B was questioned about multi-use glucometer cleaning between residents. TMA-B stated she was aware the glucometer needed to be sanitized between residents and verified she should have wiped the equipment between resident use. TMA-B pointed to the alcohol wipes on the cart containing the glucometer supplies, indicating she would utilize them to cleanse the glucometer. When specifically questioned whether she would utilize the alcohol wipes to disinfect, TMA-B responded "yes". TMA-B further clarified she was unaware the multi-use glucometer required different sanitization. When interviewed on 9/15/16, at 11:00 a.m. the director of nursing (DON) verified staff should wipe the multi-use glucometer equipment between resident use with the Sani-wipes which have bleach. When the policy for cleaning the reusable equipment was requested, the following was provided on 9/15/16, at 11:30 a.m. by the DON: "Disinfecting Reusable Equipment and Environmental Surfaces", undated, identified the following: Equipment: (a) After using reusable equipment it must be cleaned and returned to the place it is stored. Glucometer's must be cleaned after each use using the manufacturers instructions. At this time, the DON verified the	21390		

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21390	Continued From page 31 manufacturers instructions for cleaning the glucometer included using a 1:10 bleach solution or super Sani-wipes. The DON stated the facility utilized the Sani-wipes versus bleach solution. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) could review policies and procedures for proper disinfection of glucometors. Nursing staff could be educated as necessary to the importance of infection control related to cleaning glucometors. The DON or designee, along with the pharmacist, could conduct audits on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		10/25/16

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21426	Continued From page 32 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to screen 5 of 5 newly admitted residents (R28, R69, R80, R83 and R97) for tuberculosis (TB), failed to document the results of the 2nd step tuberculin skin test (TST) results for 1 of 5 residents (R83) and failed to perform a 2 step TST for 2 of 5 residents (R28 and R80). This had the potential to affect all residents residing in the facility. Findings include: R28 was admitted to the facility 7/13/16. R28's Immunization Report for date range 1/1/2015 - 9/30/2016 identified R28 had a 2 step TST on completed 1/21/15 (this was a prior admission.) A progress note dated 7/15/16 to the physician identified "Resident had 2 step mantoux done 1/20/15 do you want repeated?" The physician response was, "don't have to repeat the mantoux for me, but you {sic} protocol may be you have to." No TB screen or 2 step TST documentation was submitted for R28. R69 was admitted to the facility 4/12/16. R69's Immunization Report indicated R69 did not have a symptom screen for TB on admission. R80 was admitted to the facility 6/17/16. R80's Immunization Report for the date range 2/1/16 - 9/30/16, indicated R80 did not have a symptom screen for TB, and did not have a 2nd step TST completed.	21426	Corrected	

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21426	Continued From page 33 R83 was admitted to the facility 3/29/16. R83's Immunization Report, indicated R83 did not have a symptom screen for TB on admission and did not have the second step TST results read. R97 was admitted to the facility 3/16/16. R97's Immunization Report, indicated R97 did not have a symptom screen for TB on admission. During an interview on 9/14/16, at 2:20 p.m. the director of nursing (DON) verified that symptoms screens for TB had not been performed upon admission for R28, R69, R80, R83 or R97. She also verified that R28 did not have a 2 step TST completed upon admission, and R80 did not have a 2nd step TST completed and R83 did not have the 2nd step TST results read. The facility's policy and procedure titled "Tuberculosis, Screening Residents for" revised date July 2013, indicated "The physician will screen each new admission for possible signs and symptoms of TB" and "Any resident without documented negative TST (tuberculin skin test), BAMT (blood assay for Mycobacterium tuberculosis), or CXR (chest X-rays) within the previous 12 months will receive a baseline (two-step) TST or (one-step) BAMT upon admission. If the first TST is negative a follow-up TST will be administered 1 to 3 weeks after the initial test is read." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review policies and procedures related to the components of the infection control and TB monitoring program. Facility staff could be educated on the TB regulations and the two step	21426		

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21426	Continued From page 34 Mantoux process. The director of nursing and/or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		