DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

				ATE SURVEY AGENCY	ID: H90X Facility ID: 00750
MEDICARE/MEDICAID PROVIE NO.(L1) 245423 STATE VENDOR OR MEDICAID (L2) 925340800		3. NAME AND ADDRESS OF FACILITY (L3) CHOSEN VALLEY CARE CENTER (L4) 1102 LIBERTY STREET SOUTHEAS (L5) CHATFIELD, MN			4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9) 6. DATE OF SURVEY 10/	OWNERSHIP 28/2016 ^(L34)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual	UPPLIER CATEGORY 05 HHA 09 ESRI 06 PRTF 10 NF	02 (L7) 0 13 PTIP 22 CLIA 14 CORF	7. On-Site Visit 9. Other 8. Full Survey After Complaint
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 11 ICF/ 08 OPT/SP 12 RHC	IID 15 ASC	FISCAL YEAR ENDING DATE: (L35) 09/30
11. LTC PERIOD OF CERTIFICATIO From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 SNF 78 (L37) (L38)	78 (L18) 78 (L17)	A. In Complia Program Re Compliance1. A B. Not in Comp	A IS CERTIFIED AS: nance With equirements e Based On: cceptable POC bliance with Program and/or Applied Waivers: IID (L43)	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code * Code: B 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	7. Medical Director
16. STATE SURVEY AGENCY REM	IARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION DATE):		
17. SURVEYOR SIGNATURE Kathryn Serie, Uni	t Supervisor	Date :	1/09/2016 (L19)	18. STATE SURVEY AGENCY Kamala Fiske-Downing	APPROVAL Date: 1. Enforcement Specialist 11/09/2016 (L20
PA	RT II - TO BE	COMPLETED I	BY HCFA REGIONA	AL OFFICE OR SINGLE S	STATE AGENCY
DETERMINATION OF ELIGIBIT 1. Facility is Eligible to 1 2. Facility is not Eligible	Participate		IPLIANCE WITH CIVIL HTS ACT:		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e:
22. ORIGINAL DATE	23. LTC AGREEI	MENT 24	4. LTC AGREEMENT	26. TERMINATION ACTION	: (L30)
OF PARTICIPATION 02/01/1987	BEGINNING	G DATE	ENDING DATE	VOLUNTARY 00 01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)	02-Dissatisfaction W/ Reimburs	** - *** - *** - **********************
25. LTC EXTENSION DATE: (L27)		VE SANCTIONS n of Admissions: uspension Date:	(L44)	03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active
			(L45)		
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.	30. REMARKS	
	(L28)	03001	(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	N OF APPROVAL DATE	Posted 11/15/2016	Co.

(L33)

DETERMINATION APPROVAL

(L32)



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

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us



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

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Program Assurance Unit

Health Regulation Division

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building		I	DATE OF REV	ISIT
	B. Wing	Y	'2 .	10/28/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
CHOSEN VALLEY CARE CEN	TER	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).

ITE Y4	М	DATE Y5	ITEM Y4		DATE Y5	ITEM Y4			DATE Y5
ID Prefix		Correction	ID Prefix F0		Correction	ID Prefix	F0314 483.25(c)		Correction
Reg. #	483.10(b)(11)	Completed	Reg. #	3.20(k)(3)(ii)	Completed	Reg. #	403.23(0)		Completed
LSC		10/25/2016	LSC		10/25/2016	LSC			10/25/2016
ID Prefix	F0323	Correction	ID Prefix F0	0325	Correction	ID Prefix	F0334		Correction
Reg. #	483.25(h)	Completed	Reg. #	3.25(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			
REVIEWI STATE A		REVIEWED BY (INITIALS) KS/kfd	DATE 11/9/2016	SIGNATURE OF	SURVEYOR	03048		DATE 10/2	8/2016
REVIEWI CMS RO	ED BY	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						

NFPA 101

K0018

Reg. #

ID Prefix

Reg. #

LSC

LSC

	POST-CERTIFICATION REVISIT REPORT											
PROVIDER / SUPPLIER			0.4		DATE OF REVI	ISIT						
IDENTIFICATION NUMBI 245423	A. Building 01 -	MAIN BUILDING	01		_{Y2} 11/9/2016	Y3						
NAME OF FACILITY			STREET ADDRESS, O	STREET ADDRESS, CITY, STATE, ZIP CODE								
CHOSEN VALLEY CARE CENTER			1102 LIBERTY STREE	ET SOUTHEAST								
			CHATFIELD, MN 5592	23								
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 be corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or I provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement the survey report form).												
ITEM	DATE	ITEM	DATE	ITEM	DATE	Ē						
Y4	Y5	Y4	Y5	Y4	Y5							
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correc	ction						

Completed

10/25/2016

Correction

Completed

Reg. #

ID Prefix

Reg. #

LSC

LSC

Completed

Correction

Completed

NFPA 101

K0062

Reg. #

ID Prefix

Reg. #

LSC

LSC

Completed

10/25/2016

Correction

Completed

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: H90X

 ${\bf MEDICARE/MEDICAID\ CERTIFICATION\ AND\ TRANSMITTAL}$

PARI	1 - TO BE COMPI	LEIEDBYI	HE STAT	E SURVEY AGENCY		Facility ID: 00/50	
MEDICARE/MEDICAID PROVIDER NO.(L1) 245423	3. NAME AND AI (L3) CHOSEN V	ALLEY CARE	CENTER		4. TYPE OF ACT	ION: <u>2</u> (L8) 2. Recertification	
2. STATE VENDOR OR MEDICAID NO. (L2) 925340800	(L4) 1102 LIBER (L5) CHATFIEL		SOUTHEA	(L6) 55923	3. Termination 5. Validation 7. On-Site Visit	4. CHOW 6. Complaint 9. Other	
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SU 01 Hospital	05 HHA	09 ESRD	02 (L7) 13 PTIP 22 CLIA	8. Full Survey Aft		
6. DATE OF SURVEY 09/15/2016 L3-2 8. ACCREDITATION STATUS: (L10 0 Unaccredited		06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR END	DING DATE: (L35)	
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 78 (L18 13. Total Certified Beds 78 (L17	Compliance 1. A X B. Not in Con	e POC	gram	And/Or Approved Waivers Of 2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SN5. Life Safety Code	6. Scope of 3	Services Limit Director om Size	
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 S 78		IID	varvers	*Code: B 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)		
(L37) (L38) (L3 16. STATE SURVEY AGENCY REMARKS (IF APP		(L43) ANCELLATION I	DATE):				
17. SURVEYOR SIGNATURE	Date :			18. STATE SURVEY AGENCY	/ APPROVAL	Date:	
Wendy Willson, HFE NE II		10/13/2016	(L19)	(EZO			
PART II - TO	BE COMPLETED I	BY HCFA RE	EGIONAL	OFFICE OR SINGLE S	STATE AGENCY		
DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible	RIGI	IPLIANCE WITH HTS ACT:	H CIVIL	21. 1. Statement of Fina2. Ownership/Contr3. Both of the Above	ol Interest Disclosure Stn		
22. ORIGINAL DATE 23. LTC AG	REEMENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION		(L30)	
20. 21.0.10.	NING DATE	ENDING DAT		VOLUNTARY 00 01-Merger, Closure	<u>INVOLU</u> 05-Fail to	UNTARY De Meet Health/Safety	
A. Suspe	NATIVE SANCTIONS ension of Admissions: and Suspension Date:	(L25)		02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	on <u>OTHER</u>	der Status Change	
		(L45)					
28. TERMINATION DATE:	29. INTERMEDIARY	/CARRIER NO.		30. REMARKS			
	03001						
(L28)	22 DDEED	V OF 1 PP =	(L31)				
31. RO RECEIPT OF CMS-1539	32. DETERMINATION	N OF APPROVAL		DETERMINATION ARE	POWAI		



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:

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

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

<u>Remedies</u> - 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

<u>Informal Dispute Resolution</u> - 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

Kumalu Fishe Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us

PRINTED: 10/17/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION			(X3) DATE SURVEY COMPLETED		
		245423	B. WING _		09/	15/2016
	PROVIDER OR SUPPLIER	TER		STREET ADDRESS, CITY, STATE, ZIP CODE 1102 LIBERTY STREET SOUTHEAST CHATFIELD, MN 55923	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETION DATE
F 000	signature is not req	led in ePOC and therefore a uired at the bottom of the first	F 00	0		
F 157 SS=D	page of the CMS-29 submission of the F verification of comp Upon receipt of an a revisit of your facility validate that substate regulations has been your verification. "A recertification su complaint investigate the time of the standard that the time of the standard that the time of the standard that the complaint investigation of the standard that the time of the standard that the time of the standard that the consult with the result injury and has the printervention; a significant in the status in either life to clinical complication significantly (i.e., a rexisting form of treat consequences, or to complete the submission of the status in either life to consequences, or to consequences, or to consequences, or to consequences.	567 form. Electronic POC will be used as bliance. acceptable POC an on-site y may be conducted to intial compliance with the en attained in accordance with accordance with the en attained in accordance with the entained	F 15	7		10/25/16
ARORATORY	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		SURVEY PLETED
		245423	B. WING		09/1	5/2016
	PROVIDER OR SUPPLIER	TER	1	TREET ADDRESS, CITY, STATE, ZIP CODE 102 LIBERTY STREET SOUTHEAST CHATFIELD, MN 55923		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	§483.12(a). The facility must alsand, if known, the ror interested family change in room or a specified in §483.1 resident rights underegulations as specithis section. The facility must rethe address and phlegal representative. This REQUIREMENT by: Based on observations staff interview the faphysician of the sign experienced for 1 of for nutrition. Findings include: R69 was admitted of that included GERE disease), peptic ulcourseless, anxiety and Minimum Data Set R69 with a Brief Interested for 1 of the sign experienced for 1 of the s	so promptly notify the resident esident's legal representative member when there is a roommate assignment as 5(e)(2); or a change in er Federal or State law or sified in paragraph (b)(1) of cord and periodically update one number of the resident's e or interested family member.	F 157	This plan and response to MCS-25 regarding Tag F 157, is written sole maintain certification in the Medical Medical Assistance programs. We to preserve our right to dispute thes findings in their entirely should any remedies be imposed. Chosen Valley Care Center continu promptly notify the resident, his or hattending Physician, and represent changes in residents medical/mer condition and/or status. Chosen Valley Care Center's Cha	ly to re and wish se es to ner ative of	
	impairment and ide with eating with only The nutrition section	ntified he was independent y set up assistance needed. n of the MDS identified R69 7 pounds and indicated no		a Resident s Condition of Status F has been reviewed. R69 's physician was notified on C 10, 2016 of weight loss, current we and result of food intake log.	Policy October	

AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245423	B. WING		09/1	15/2016
	PROVIDER OR SUPPLIER	TER		STREET ADDRESS, CITY, STATE, ZIP CODE 1102 LIBERTY STREET SOUTHEAST CHATFIELD, MN 55923		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETION DATE
F 157	and weight tracking sustained a signific admission and more two months (7/1/16 (most current) indice 9/6/16-199.8 pound with a 10% weight 18/1/16-214.0 lbs which weight 18/1/16-224.0 lbs 6/2/16-223.0 lbs 5/10/16-224.0 lbs 5/10/16-224.0 lbs 5/10/16-225.0 lbs 5/10/16-225.0 lbs During observation was seated at the content of the dining room. During observation was observed the evening meal. It table for a long time the dining room. During observation 9/14/16, at 12:00 p. following food items to ast slice, hash bruturkey sandwich. Addining room it was of bacon, 1/2 piece	on 9/13/16, at 5:09 p.m. R69 lining room table in his as served a lemon bar, 1 a, boiled potatoes and spinach. to consume less than 1/2 of R69 was noted to sit at the period just looking around of the brunch meal on m. R69 was served the period just looking around of the brunch meal on m. R69 was served the size 2 strips of bacon, 1 buttered own triangle, soup and half a tailed to 1/4 piece of toast, 1/2 hash brown	F 15	,	ducated adition or aff will 1st, and dent s for two will be quality	
	triangle, none of the consumed approxin the certified dietary	e turkey sandwich and had mately 2 bites of soup. When manager (CDM) observed the ell, he did not eat very good.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		E SURVEY MPLETED
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F 157	status were as note (1) A dietary note of identified R69 as a diagnoses as: HTN disease) and CHF was identified that (diuretic) medication and was at risk for documented as Nowas independent with the thin 75% of meals own teeth on lower swallowing problem and height were reinches (5' 10"). (2) A dietary note of identified R69 with advanced dementified R69 with advanced dementified R69 included La	ated to to R69's nutritional	F 15	7		
	identified as independent inde	endent with eating and intake greater than 75% of his food. Illowing problems; weight 3 lbs. and weight within usual so identified R69 was at risk with need for NAS diet, due to to body weight (BW) and BMI normal labs. The note conitor intake, weights and y/MD order; notify CDM, RD as essment/dietary note dated .m. identified R69's weight at a NAS diet related to heart				

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	PROVIDER OR SUPPLIER	TER		STREET ADDRESS, CITY, STATE, ZIP COL 1102 LIBERTY STREET SOUTHEAST CHATFIELD, MN 55923)E	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	
F 157	that R69 would try to with him at the diniridentified that R69 wand would want to go no chewing or swall the care plan was regoals or approached. The medical record documentation relations other than weigexperienced a 27 lb recorded weight of lbs on 9/6/16. The evidence of physicisignificant weight low. When interviewed certified dietary matabout R69's record 7/1/16. The CDM in the weight loss and weight recorded was R69's weight loss and weight recorded was R69's weight loss on some dental work or related to the admit the CDM stated the monitored but she loss as a concern. So could have been wheelchair. The CD registered dietician	75-100% of meals served and o eat his wife's food, who sat a room table. The note also would refuse to eat at times go back to room. There were lowing problems identified and eviewed with no changes in s. I lacked any further ted to dietary status/weight ght recordings. R69 b. weight loss since the 227 lbs on 7/1/16 and 198.9 medical record lacked any an notification of the	F 1	57		
	any weight loss. When interviewed of	on 9/14/16, at 11:27 a.m. N)-C stated she was unaware				

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			TE SURVEY MPLETED		
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	PROVIDER OR SUPPLIER	TER		STREET ADDRESS, CITY, STATE, ZIP CODE 1102 LIBERTY STREET SOUTHEAST CHATFIELD, MN 55923		
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F 157	RN-C stated she w weight loss until the was conducted and notified. When interviewed director of nursing should have report loss to the physicia also have been been been been been been been be	and had not been notified. Fould not have identified the enext quarterly assessment of she would expect to be on 9/14/16, at 11:59 a.m. the (DON) verified nursing staff ed/responded to the weight an and verified the RD should en notified of the weight loss. The was unaware of the weight en and verified the RD should en notified of the weight loss. The was unaware of R69's weight en and verified the RD should en notified of the weight loss. The was unaware of R69's weight en and the facility on 8/4/16 and the staff review as the facility on 8/4/16 and the staff review. The registered nurse (RN)-A on the RN-A stated she would entered to review. The registered nurse (RN)-A on the RN-A stated she would entered the staff reweigh the resident for for non-health related significant change in weight. Change in Resident's staff revised September 2013, licy Statement; The facility yethe resident, his or her the name of the resident of the resident's medical/mental	F 15	7		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 157	(1) The nurse super the resident's attend physician when the a. An accident or b. A discovery of in c. A reaction to me d. A significant chaphysical/emotional/e. A need to alter the treatment significant f. Refusal of treating. A need to transform treatment center. h. A discharge with i. Instructions to min the resident's cor (2) A "Significant chor improvement in that: a. Will not normally intervention by staff disease-related clin b. Impacts more the health status. c. Requires interdistrevision to the care d. Ultimately is basclinical staff and the Resident Assessment 483.20(k)(3)(ii) SEF PERSONS/PER CATThe services provided by the status of the services provided the services provided by the services provided the services provided by the services provided the services provided the services provided by the services provided	ervisor/charge nurse will notify ding physician or on-call re has been: incident involving the resident njuries of unknown origin. edication ange in the resident's mental condition. the resident's medical ntly. ment or medications fer the resident to a hospital or hout proper medical authority. notify the physician of changes andition. It is a decline the resident's health status or resolve itself without for by implementing standard incal interventions. It is an one area of the residents esciplinary review and/or plan; and sed on the judgement of the equidelines outlined in the ent Instrument [RAI].		282			10/25/16

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245423	B. WING		09/1	5/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 30/11	0,1010
CHOSEN	VALLEY CARE CEN	TER		I102 LIBERTY STREET SOUTHEAST CHATFIELD, MN 55923		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	This REQUIREME by: Based on observareview the facility for care to reduce the of 4 residents (R69 Findings include: R69 was admitted Minimum Data Set 7/10/16, identified Mental Status (BIM severe cognition doi identified R69 requistaff with toileting a identified R69 had his admission and with 2 or more falls Fourteen falls were notes from 4/12/16 that R69 attempted self-cares repeated 9/13/16 at 3:55 p.m. R69 was found by chair alarm soundi and recliner. The nattempting to self to The interdisciplinar dated 9/14/16, at 8 interventions to incobed time and when protestors at all time able for increased checks while in roominutes for increased checks while in roominutes for increased	tion, interview and document ailed to implement the plan of risk of injury during falls for 1 b) reviewed for falls. on 4/12/16. The quarterly (MDS) assessment dated R69 with a Brief Interview for IS) score of 4 indicating a efficit. The MDS further sired limited assistance of one and transfers. Also, the MDS sustained 2 or more falls since had sustained minor injuries is documented in progress a until 9/13/16 which identified it self transfers and/or ally since admission. On an a progress note identified staff sitting on his floor, with ang, between his wheelchair note identified R69 was transfer without assistance. The transfer sitting on the complete is a manifer without assistance. The complete is a manifer without assistance is a manifer without assistance. The complete is a manifer without assistance is a manifer without assistance. The complete is a manifer without assistance is a manifer without assistance. The complete is a manifer without assistance is a manifer without assistance. The complete is a manifer without assistance is a manifer without assistance is a manifer without assistance. The complete is a manifer without assistance is a manifer without assistance is a manifer without assistance. The complete is a manifer without assistance is a manifer without assistance is a manifer without assistance. The manifer without assistance is a	F 282	This plan and response to MCS-28 regarding Tag F 282, is written sole maintain certification in the Medica Medical Assistance programs. We to preserve our right to dispute thes findings in their entirely should any remedies be imposed. The policies and procedures for implementation of care plans and oplanning have been reviewed and fappropriate. After it was known that the resident (R69) plan of care to reduce the risinjury during falls was not being foll the nursing assistants were educat Resident 69 's fall interventions that to be followed. They were re-educat the locations of the care plans and to find fall interventions on the care for all residents. All residents who reside at Chosen Care Center have the potential to be affected by this deficient practice. Nursing Assistants, Nurses, and The have initially been notified in shift rethe expectations of following fall interventions according to plan of owhat the outcomes could be of not following care plans, where to idented there are questions regarding the particular of the care questions regarding the plans of the care questions regarding there are questions regarding there are questions regarding the plans of the care questions regarding the plans of the care questions regarding there are questions regarding the plans of the care questions regarding there are questions regarding the plans of the care plans and the plans of the care plans and the plans of the care plans and	ely to re and wish see care found t s sk of lowed, red on at are ated on where e plan Valley be MAs eport of care, tify ho to g care	
	cares/dressing ass	sed confusion); (6) morning istance at 5:00 a.m5:30 a.m.; ares right after supper; (8)		see if there are questions regarding plans. All licensed and unlicensed will be re-educated on resident care	staff	

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CENTER	45 FOR MEDICARE	& MEDICAID SERVICES			U	<u>NR NO.</u>	<u>0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CHOSEN	I VALLEY CARE CEN	TER			102 LIBERTY STREET SOUTHEAST CHATFIELD, MN 55923		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	at bedside and (10) wheelchair cushion care plan dated 7/2 mobility related to it impaired balance shistory of trans-isch required assistance and R69 utilized a mobility. During observation 9/13/16, at 5:41 p.n answer the call lighenter the bathroom remove R69 away wheelchair and leaveroom, R69 immediate the bathroom and a toileting. R69 attenthe chair alarm. At (RN)-A responded and entered the roonto the toilet. It was stood in front of the unable to pivot self assistance. When interviewed of stated she had to least assistance to toilet. It was stood in front of the unable to pivot self assistance. When interviewed of stated she had to least assistance to toilet. It was stood in front of the unable to pivot self assistance. During a subseque	rm at all times; (9) keep walker place dicem above and below. These were identified on the 1/16 as R69 had impaired increased weakness and econdary to dementia and nemic attacks (TIA's) and ambulation and positioning wheelchair or walker for of a morning cares on in. NA-A entered R69's room to than and noted R69 attempting to it. NA-A was observed to from the bathroom door in his we the room. After staff left the ately wheeled himself back into attempted independent in the activated alarm sound om and to assist R69 to pivot its observed that when R69 it toilet, he was shaky and and sit on toilet without on 9/13/16, at 5:50 p.m. NA-A eave the room to locate staff to athroom. NA-A stated she was risk for falling and required During this observation R69 in protectors attached as a plan.	F 2	282	with emphasis on Fall Interventions staff in-services on October 20th, 2 and 24th, 2016. A Fall Intervention Audit was develor and will be completed to ensure the interventions are followed accordinglan of care to reduce the risk of induring falls. The Director of Nursin her designee will complete these monce weekly for four weeks and the quarterly audits will be completed a presented at the Quality Improvem Meeting for one full year.	oped at fall g to jury g or nonitors en	
		IA-A should have stayed with					

stated, "He [R69] is a huge fall risk". RN-A stated

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	TER		1102 LIBER	DRESS, CITY, STATE, ZIP CODE RTY STREET SOUTHEAST .D, MN 55923		
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F 282	acceptable to leave aware he will attem When interviewed overified when she used a cares he did not has further indicated should had worn them durifurther stated that if the hip protectors of the hip protectors of the hip protectors of the use of the hip protect to the	ed more training as it was not R69 alone when staff are pt to self transfer. on 9/13/16, at 6:50 p.m. NA-B ndressed R69 for bedtime ve his hip protectors on and e was unaware whether he ng the entire shift. NA-B R69 would often refuse to put n. oh RN-C on 9/15/16 at 8:56 care plan had just been hat R69 often would refuse rotectors. RN-C verified the ons had indicated that R69 oftectors at all times. Fall intervention was received ENT/SVCS TO RESSURE SORES rehensive assessment of a must ensure that a resident ity without pressure sores ressure sores unless the condition demonstrates that ble; and a resident infection and e healing, prevent infection and	F 2				10/25/16
	by: Based on observat	ion, interview and document		This p	lan and response to MCS-29	567	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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F 314	review the facility for reassess and imple of 1 resident (R9) in Stage III pressure. Findings include: A significant chang assessment dated at risk for pressure pressure ulcers at Assessment (CAA) mild risk for PU set assistance with bet frequently incontine CAA identified no concern and the impressure reducing mattress on bed, to hours. However, or assessment dated ulcer was identified. During observation R9 was noted lying gripper socks on bet heels/feet were not her knees. At 8:33 (LPN)- A verified R and R9 did not have protectors were for Review of the care interventions that in offload R9's heels turn and reposition or chair and (3) give calorie and protein wound preventions.	eailed to comprehensively ement timely interventions for 1 reviewed who developed a sulcer located on the ankle. e Minimum Data Set (MDS) 1/10/16, identified R9 as being ulcers (PU) but had no (0) this time. The Care Area dated 1/12/16, identified R9 at condary to requiring extensive demobility (2 staff) and ent of bowel and bladder. The open areas (skin) nor areas of terventions included the use of cushion in w/c (wheelchair), lipum and reposition every 2 the quarterly MDS 6/26/16, a stage II pressure date in the protectors and at floated as pillow was under a.m. licensed practical nurse 9's heels/feet were not floated the heel protectors on. No heel	F 3	regarding Tag F 314, is writt maintain certification in the I Medical Assistance program to preserve our right to dispit findings in their entirely show remedies be imposed. Chosen Valley Care Center ensure that based on the coassessment of a resident, the ensure that a resident who efacility without pressure sores develop pressure sores unleindividual is clinical conditioned demonstrates that they were and a resident having press receives necessary treatme services to promote healing infection, and prevent new sideveloping. The policies and procedures comprehensively assessing residents is skin condition and have been reviewed and for appropriate. The care plan was updated 11, 2016 for R9 to reflect the interventions required to predeterioration and promote hankle ulcer. R9 was recentle podiatrist on October 3, 201 measures 3mm x 3mm x 1m podiatrist note, ulcer has no undermining, no tunneling of ulcer is improving. All residents who reside at Calledon and provided at Calledon and provided at Calledon and proving.	Medicare and is. We wish ute these uld any strives to imprehensive the facility must enters the es does not ess the in e unavoidable; ure sores int and its factors and on October exert further ealing of the y seen by 6 and ulcer inm. Per odor, no r pain and	

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F 314	right ankle nor had use of the heel profescale for predicting identify the pressur scale assessments nor any other reass tolerance) related to Review of the Weenoted: 4/16/16- bruise to respond to the physimplemented. 4/23/16- area to right cm by 0.6 cm and in (NS) and covered with foam 5/7/16- area to right covered with foam 5/7/16- area to right covered with increase in measurement of 1 5/14/16-scabbed at cm by 1 cm. 5/23/16- wound/scameasures 1 cm by pad. 5/29/16-continues to ankle (no measure 7/9/16-continues to ankle. 8/27/16-right ankle 9/3/16-right ankle with	Stage III PU located on the it been updated to reflect the tector. Review of the Braden PU risk dated 6/23/16, did not e ulcer. No further Braden were conducted since 6/23/16 tessments (e.g. tissue to the PU. kly Skin Charting was as ight outer ankle measuring 0.6 (cm) and fluid filled. A note vician. No new intervention th outer ankle measures 0.6 s cleansed with normal saline with foam dressing. It outer ankle, area is dark, 3 cm, no drainage and and changed every three days. It ankle measures 1 cm by 1 to the company of t	F 314	Care Center have the potential to affected by this deficient practice. wound committee will meet every weeks. The committee includes: Case Managers, RN Nurse Mana DON, and the CDM. The first mescheduled for October 13, 2016. All staff will be educated on Octol 21st, and 24th, 2016 on our Presulcer Treatment Policy which incl reassessing a resident once they developed a pressure ulcer and implementing the appropriate interventions once assessment is completed. Pressure Ulcer Intervention Audit completed by the Director of Nursher designee once weekly for fou and then quarterly audits will be completed and presented at the Climprovement Meeting for one full	will be sing or r weeks	

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F 314	tissue loss. Subcutabone, tendon or mumay be present but the tissue loss. Matunneling). Review of the Pressis as follows for the 6/4/16-0.8 cm by 0 pressure ulcer (par involving epidermis and presents as ab crater). Treatment: (NS) apply Aquacel every 3 days and as 6/19/16-0.5 cm by 0 change in treatmen 7/2/16-0.8 by 0.9 cr change in treatmen 7/2/16-0.8 by 0.9 cr change in treatmen 7/16/16- 0.9 by 0.6 Change in treatmen Aquacel and non-adays and prn. 7/23/16-0.8 by 0.8 change III to Sta 7/30/16-0.8 cm by Stage III; No change 8/7/16-0.8 by 0.7 by Treatment changed ulcer on right ankle Duoderm and chan 8/14/16-0.8 by 0.8 change treatment. 8/20/16-0.5 by 0.5 chontinue same treatment.	aneous fat may be visible but uscle are not exposed. Slough a does not obscure the depth of y include undermining and sure Ulcer Weekly Flow Sheet right ankle: 8 cm, no depth, Stage II tial thickness skin loss and or dermis. Superficial rasion, blister or shallow cleanse with normal saline and cover with Duoderm sneeded (prn). 9.4 cm, no depth, Stage II; No t. cm, no depth, Stage III; documented with change in PU age III nor change in treatment. 0.8 cm by 0.1 cm depth, e in treatment plan. cover with Aquacel and ge every 5 days and prn. cover with Aquacel and ge every 5 days and prn. cover by 0.1 cm depth, Stage III; cm by 0.1 cm depth, Stage III;	F 31	4		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 314	When interviewed or registered nurse (Ridentified to be at riulcers and developing the right ankle after RN-A confirmed no conducted during the ulcer had deterioral Although the treatm of care did not refler required to prevent promote healing of The undated facility Treatment indicated care of an existing Tissue Tolerance Ecommunication boaresident to be reposed and chair; (11) minimum once daily surfaces and determindicated; (13) Treatment indicated; (13) Treatminimum every 14 improvement re-evesupport/off-loading/treatment; and (14)	om, no depth, healing, Stage on 9/14/16, at 1:04 p.m. (N)-A verified that R9 was sk for developing pressure ed a Stage III pressure ulcer to admission to the facility. Further reassessments were ne time when the pressure ted from a Stage II to Stage III. The tents were changed, the plan et the current interventions further deterioration and/or the ankle PU. If policy titled, Pressure Ulcer of the following protocol for the pressure ulcer: (9) Start valuation and notify nurses on eard; (10) Change care plan for sitioned every 1 hour while in Pressure ulcer to monitored at the ty; (12) Re-evaluate supportive mine if new interventions are attent to be re-evaluated at days for effectiveness. If no	F3	14			
F 323 SS=D	483.25(h) FREE OI HAZARDS/SUPER	VISION/DEVICES	F 3	23			10/25/16
	environment remain	sure that the resident ns as free of accident hazards each resident receives					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION ((X3) DATE SURVEY COMPLETED	
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F 323	adequate supervisi prevent accidents. This REQUIREME	age 14 on and assistance devices to NT is not met as evidenced	F 323			
	review the facility far manner to reduce to 4 residents (R69) re Findings include:	tion, interview and document ailed to provide care in a he risk of fall and injury for 1 of eviewed for accidents.		This plan and response to MCS-256 regarding Tag F 323, is written solely maintain certification in the Medicare Medical Assistance programs. We want to preserve our right to dispute these findings in their entirely should any remedies be imposed.	to and vish	
	Minimum Data Set 7/10/16, identified I Mental Status (BIM severe cognition de identified R69 requ staff with toileting a identified R69 had	on 4/12/16. The quarterly (MDS) assessment dated R69 with a Brief Interview for S) score of 4 indicating a eficit. The MDS further ired limited assistance of one nd transfers. Also, the MDS sustained 2 or more falls since had sustained minor injuries.		The policies and procedures for falls which includes fall interventions, have been reviewed and found appropriate. On September 13, 2016 it became ke that NA-A, who had been training, has answered R69 call light then left the resident is room to find assistance. received verbal education to educate how she should have safely handled.	nee. nown ad NA-A	
	notes identified that and/or self-cares re (1) On 9/13/16, at sitting on his floor, between his wheeled to self transfer with 8/30/16, at 6:55 a.r patio outside the frowheel himself back wheelchair cushion	documented and progress t R69 attempted self transfers epeatedly as noted: 3:55 p.m. R69 found by staff with chair alarm sounding, chair and recliner; attempting out assistance. (2) On n. R69 was seated on the ont door and was attempting to in the facility when his slipped out of his wheelchair th cushion onto the patio. No		how she should have safely handled situation. Additionally the nursing assistants were educated on Reside 69 s fall interventions that are to be followed. They were re-educated on locations of the care plans and wher find fall interventions on the care pla all residents. Additionally resident splan had been updated on September 2016 to reflect that resident R69 ofter refuses use of hip protectors. All residents who reside at Chosen No Care Center have the potential to be	nt the e to n for s care er 15, en	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		SURVEY PLETED
		245423	B. WING			09/1	15/2016
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CHOSEN	I VALLEY CARE CEN	TER			102 LIBERTY STREET SOUTHEAST HATFIELD, MN 55923		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPORTION OF T	BE	(X5) COMPLETION DATE
F 323	(3) On 8/19/16, at 6 heard sounding and was observed sittir appeared to be tryin (4) On 8/3/16, at 4 staff responded and the floor in the midd self ambulate to the (5) On 8/2/16, at 10 (NA) was assisting of a gait belt, R69 a reaching the toilet at (6) On 7/31/16, at 4 sounding, staff arriv witnessed to fall babeside bed; receive treatment. (7) On 7/29/16, at 11 his bed to the bathr without assistance bedside table; recenursing treatment. (8) On 7/29/16, at toileted without ass (9) On 7/13/16, at 6 the floor by his wife evening meal. (10) On 7/5/16, at 9 lying on his back in his pants around hi laceration to his left (11) On 6/22/16, at the floor in his bath the bathroom. (12) On 5/23/16, at the floor in his room 5/16/16, at 9:30 a.n.	3:00 p.m. R69's bed alarm was d when staff entered room R69 ng on the floor in his room; ng to get ready for bed. 3:00 a.m. R69's alarm sounded, d R69 was observed sitting on dle of his room; attempted to be bathroom by himself. 3:30 a.m. a nursing assistant R69 to the toilet with the use attempted to sit before and was lowered to the floor. 3:39 a.m. R69's alarm was red at the room R69 was okwards and land on floor and abrasions which required 3:30 R69 was walking from room with use of walker and fell backwards into his ived two skin tears -required 3:28 p.m. R69 fell again, istance. 3:28 p.m. R29 was found on after returning from the 3:10 a.m. R69 was was found the middle of his room with s ankles; sustained a	F3	323	affected by this deficient practice. Nursing Assistants, Nurses, and Thave initially been notified in shift rethe expectations of following fall interventions according to plan of what the outcomes could be of not following care plans, where to iden residents fall interventions, what to resident refuses care or intervention who to see if there are questions regarding care plans. All licensed unlicensed staff will be re-educated resident care plans with emphasis Interventions on October 20th, 21s 24th, 2016. A Safe Environment Audit was deviand will be completed to ensure the resident environments are free of paccidents to reduce the risk of falls injury. This monitor includes obserstaff answering call lights to ensure interactions are completed safely a potential hazards are identified. The Director of Nursing or her designed complete these audits once weekly four weeks and then quarterly audit be completed and presented at the Quality Improvement Meeting for o year.	eport of eare, tify do if a ns, and and don on Fall t, and eloped at potential and/or ving e that all ne e will of for ts will end and the eloped elo	

at 5:19 p.m. R69 was found seated on the floor in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		245423	B. WING _		09	/15/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1102 LIBERTY STREET SOUTHEAST CHATFIELD, MN 55923	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 323	9/13/16, at 5:41 p.r answer the call light enter the bathroom remove R69 away wheelchair and lea room, R69 immediathe bathroom and a toileting. R69 atterthe chair alarm. At (RN)-A responded and entered the roonto the toilet. It was stood in front of the unable to pivot self assistance. When interviewed stated she had to lease the stated she had to lease the total the did not have his hip directed by his care. During a subseque p.m. RN-A stated NR69 and called sor stated, "He [R69] is staff definitely need acceptable to leave aware he will attern. When interviewed verified when she did not have his hip directed by his care.	of a morning cares on m. NA-A entered R69's room to at and noted R69 attempting to a. NA-A was observed to from the bathroom door in his ve the room. After staff left the ately wheeled himself back into attempted independent mpted to stand which activated 5:45 p.m. registered nurse to the activated alarm sound from and to assist R69 to pivot as observed that when R69 to toilet, he was shaky and and sit on toilet without on 9/13/16, at 5:50 p.m. NA-A eave the room to locate staff to athroom. NA-A stated she was risk for falling and required. During this observation R69 to protectors attached as a plan. Interview on 9/13/16, at 6:33 NA-A should have stayed with meone to help her. RN-A stated ded more training as it was not a R69 alone when staff are not oself transfer.	F 32	3			
		ave his hip protectors on and aware whether he had them					

-	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		245423	B. WING			09/-	15/2016		
	PROVIDER OR SUPPLIER I VALLEY CARE CEN	TER		11	TREET ADDRESS, CITY, STATE, ZIP CODE 102 LIBERTY STREET SOUTHEAST HATFIELD, MN 55923				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 323	R69's care plan daimpaired mobility reand impaired balanhistory of trans-isch required assistance and R69 utilized a mobility. The follow risk included: (1) as walker; (2) one stat socks on at bedtim reach; (4) check evneeds have been nrefusal of care have assist; (6) offer everavoid attempt to incrisk of falling; (7) mof unsteady gait, ur leaning, tilting, dizz vision; (8) teach an sitting or laying posconduct fall assess checking ambulation bowel and bladder diagnoses, endural status, medications protectors on at all. The interdisciplinar dated 9/14/16, at 8 interventions to incobedtime and when protestors at all time able for increased schecks while in roominutes for increased schedules.	NA-B further stated that R69 to put the hip protectors on. Ited 7/21/16, identified R69 had elated to increased weakness are secondary to dementia and nemic attacks (TIA's) and a ambulation and positioning wheelchair or walker for ring interventions to reduce fall esist of one staff to walk with ff assistance to put gripper e; (3) call light is always within very 1 hour in room to ensure the and offer toileting; (5) if another staff attempt to ening care right after supper to dependently perform cares and anonitor for signs and symptoms insteady balance, poor posture, iness, fatigue, poor/double d remind to rise slowly from sitions to avoid dizziness; (9) sment at least quarterly, on, balance blood pressure, issues, coordination, nce, history of fall, mental and vision; and (10) hip	F3	323					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245423	B. WING		09 /-	15/2016
	PROVIDER OR SUPPLIER	rer .	1.	TREET ADDRESS, CITY, STATE, ZIP CODE 102 LIBERTY STREET SOUTHEAST CHATFIELD, MN 55923		
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F 323 F 325 SS=D	personal safety alar at bedside and (1) personal safety and safety alar alar at bedside and (1) personal safety alar at bedside and safety alar at least a bedside and safety alar at least and safety alar at least at least at least at least at least at least and safety alar at least at le	res right after supper; (8) rm at all times; (9) keep walker place dicem above and below th RN-C on 9/15/16 at 8:56 care plan had just been that R69 often would refuse rotectors. RN-C verified the pons had indicated that R69 ptectors at all times. Fall intervention was received INTRITION STATUS PABLE t's comprehensive cility must ensure that a ptable parameters of nutritional ty weight and protein levels, s clinical condition this is not possible; and apeutic diet when there is a	F 323			10/25/16
	by: Based on observat review the facility fa weight loss was ide necessary intervent	NT is not met as evidenced ion, interview and document iled to ensure a significant ntified and evaluated so the ions could be implemented for previewed for nutrition and cant weight loss.		This plan and response to MCS-25 regarding Tag F 325, is written sole maintain certification in the Medical Medical Assistance programs. We to preserve our right to dispute thes findings in their entirely should any	ly to re and wish	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SU COMPLE	
		245423	B. WING		09/15/2	2016
	PROVIDER OR SUPPLIER	TER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1102 LIBERTY STREET SOUTHEAST CHATFIELD, MN 55923		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE CC	(X5) DMPLETION DATE
F 325	that included GERI dementia, stage 3 kdepression. R69's of (MDS) assessment Interview for Mental indicating severe condentified he was in only set up assistant section of the MDS 227 pounds and incorproblems. During review of R6 and weight tracking sustained a significal admission and more two months (7/1/16 indicated the follow 9/6/16-199.8 pound with a 10% weight 18/1/16-214.0 lbs whince 7/1/2016. 7/1/16-227.0 lbs 6/2/16-223.0 lbs 5/10/16-224.0 lbs 5/10/16-224.0 lbs 5/10/16-225 Lbs During observation was seated at the condended wheelchair. R69 was buttered bread slice.	on 4//12/16, with diagnoses D, peptic ulcer, hypertension, kidney disease, anxiety and quarterly Minimum Data Set identified R69 with a Brief I Status (BIMS) score of 4 ognitive impairment and dependent with eating with nee needed. The nutrition identified R69 with a weight of dicated no nutritional	F 325	remedies be imposed. Chosen Valley Care Center will conto ensure that all residents maintain acceptable parameter of nutritional such as body weight and protein leunless the resident is clinical condidemonstrates that this is not possible. The Weight Assessment and Intervence Policy has been reviewed and foun appropriate. New food intake was completed for on October 9, 2016. The new intake revealed that R69 consumes 75% of meals. On October 5, 2016 a new was obtained and R69 is current we 210.4 pounds. All residents who reside at Chosen Care Center have the potential to be affected by this deficient practice. Nursing Assistants, Nurses, and The have been re-educated on the Weight Assessment and Intervention Policishift report. All licensed and unlice staff will be re-educated on our Weight Assessment and Intervention Policishift report. All licensed and unlice staff will be re-educated on our Weight Session and Intervention Policishift report. All licensed and unlice staff will be re-educated on our Weight Loss is determined on Octoboth, 21st, and 24th, 2016. Weight Loss Intervention Audit will completed by the Certified Dietary Manager or her designee monthly fronths and then quarterly audits weight loss is determined on Octoboth and then quarterly audits weight loss is determined and then quarterly audits weight loss in the quarterl	n an status, vels, tion ole. ention d R69 se of his weight eight is Valley e MAs ght y in nsed ight y which ken if ober be or two	

Facility ID: 00750

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPPI JER/CLIA

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		245423	B. WING _		09	/15/2016	
PREFIX TAG (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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.				STREET ADDRESS, CITY, STATE, ZIP CODE 1102 LIBERTY STREET SOUTHEAST CHATFIELD, MN 55923			
PRÉFIX	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 325	table for a long time the dining room. During observation 9/14/16, at 12:00 p. following food items toast slice, hash broturkey sandwich. Addining room it was of bacon, 1/2 piece triangle, none of the consumed approximate certified dietary tray she stated, "We He is like that some Progress notes relastatus were as note (1) A dietary note didentified R69 as and diagnoses as: HTN disease) and CHF was identified that I (diuretic) medicatio and was at risk for documented as No was independent with than 75% of meals own teeth on lower swallowing problem and height were reginches (5' 10"). (2) A dietary note didentified R69 with advanced dementia disease). Medicatio orders and included	of the brunch meal on .m. R69 was served the s: 2 strips of bacon, 1 buttered own triangle, soup and half a t 12:45 p.m. when R69 left the noted he consumed 1/4 piece of toast, 1/2 hash brown e turkey sandwich and had mately 2 bites of soup. When manager (CDM) observed the ell, he did not eat very good. etimes." ated to to R69's nutritional ed: ated 5/3/16, at 6:16 a.m. a 88 yr old male with (hypertension), KD (kidney (congestive heart failure). It R69 was administered Lasix n due to diagnosis of edema dehydration. R69's diet was Added Salt (NAS) diet. R69 with eating and intake greater R69 had upper dentures and jaw. No chewing nor is documented. His weight corded as 230 lbs and 70	F 32	Improvement Meeting for one	full year.		

OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			TE SURVEY MPLETED
	245423	B. WING		09	/15/2016
PROVIDER OR SUPPLIER	TER		1102 LIBERTY STREET SOUTHEAS	CODE	
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	N SHOULD BE	(X5) COMPLETION DATE
R69 was identified and intake usually of his food. No che weight documente usual range. The nrisk due to diagnos to multiple meds, d BMI high and due tidentified staff to mhydration per policy needed. (3) A quarterly asse 7/12/16, at 11:11 a. 227 lbs., provided failure, consumed that R69 would try with him at the dinicidentified that R69 and would want to no chewing or swal and the care plan vin goals or approach	as independent with eating consuming greater than 75% wing or swallowing problems; d as 223 lbs. and weight within ote also identified R69 was at ses with need for NAS diet, due lue to body weight (BW) and to abnormal labs. The note conitor intake, weights and y/MD order; notify CDM, RD as essment/dietary note dated .m. identified R69's weight at a NAS diet related to heart 75-100% of meals served and to eat his wife's food, who sat ng room table. The note also would refuse to eat at times go back to room. There were llowing problems identified. was reviewed with no changes thes.	F 32			
documentation relations other than weilness other than weilness other than weilness other than weilness other than deat fine and was alplan interventions if (1) Will continue to (2) Provide with the and describe food and describe food in the weight of th	ated to dietary status/weight ght recordings. ted 7/1/16, identified R69 could ble to feed himself. The care ncluded: feed himself with set up daily. It is assistive eating devices/table and location on plate if the table that help distinguish where things are if needed.				
	PROVIDER OR SUPPLIER VALLEY CARE CEN SUMMARY STA (EACH DEFICIENC) REGULATORY OR L Continued From pa R69 was identified and intake usually of his food. No che weight documente usual range. The nrisk due to diagnos to multiple meds, of BMI high and due to identified staff to meded. (3) A quarterly asse 7/12/16, at 11:11 a. 227 lbs., provided failure, consumed that R69 would try with him at the dinicidentified that R69 and would want to no chewing or swa and the care plan win goals or approact. The medical record documentation relations of the medical record documen	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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(3) Place things on the table that help distinguish items and tell him where things are if needed.	PROVIDER OR SUPPLIER VALLEY CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 21 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. 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(3) Place things on the table that help distinguish Items and tell him where things are if needed.	PROVIDER OR SUPPLIER VALLEY CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (FLAND DEFICIENCY) STREET ADDRESS, CITY, STATE, ZIP CODE 102 LIBERTY STREET SOUTHEAST CHAFFIELD, MN 55923

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245423	B. WING		09/	15/2016	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1102 LIBERTY STREET SOUTHEAST CHATFIELD, MN 55923			1 03/13/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFICIENCY)	D BE	(X5) COMPLETION DATE	
F 325	eating. If not eating resident would like different textures: or nectars) or thinner Observe for signs a swallowing difficult (6) Offer/provide mas needed. (7) Remind to sit up and after meals to (8) Arrange for a Shave some helpful. When interviewed certified dietary mas about R69's record 7/1/16. The CDM is the weight loss and weight recorded was R69's weight loss and weight recorded was R69's weight loss and weight recorded was related to the admit The CDM stated the monitored but she loss as a concern. loss could have be wheelchair. The CI registered dietician facility on 8/4/16 ar R69 had not been any weight loss. When interviewed registered nurse (Fof the weight loss as RN-C stated she weight signs and the weight loss as RN-C stated she weight signs and the weight loss as RN-C stated she weight signs are signs and the weight loss as RN-C stated she weight signs are signs as a concern.	ow R69 was doing when g/drinking something, ask what . Offer the same food in a offer thicker fluids (such as fluids (such as water). and symptoms of choking or ies and treat immediately. It with nutritional supplements pright for 30 minutes before decrease the risk of aspiration. peech Therapist. They may	F 325				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245423	B. WING _		09	/15/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 1102 LIBERTY STREET SOUTHEAS CHATFIELD, MN 55923	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 325	notified. The medical recomphysician, register evaluated and/or pto the weight loss. When interviewed director of nursing should have report loss and verified the been notified of the she was unaware. On 9/14/16, at 12:00 via phone. The RD loss and stated shorecord when she with 9/13/16. The RD staff make her away but would not compave R69's medical. During interview with 9/14/16 at 1:46 p.n expect to be notified significant weight liproceed to request accuracy and look conditions for the staff the facility policy. The facility policy weight Loss-Clinical.	d lacked any evidence of the ed dietician or nursing staff out interventions in place related on 9/14/16, at 11:59 a.m. the (DON) verified nursing staff red/responded to the weight the RD should also have been as weight loss. The DON stated of the weight loss. The DON stated of the weight loss. 25 p.m. the RD was contacted of was unaware of R69's weight at the facility on 8/4/16 and the tated she would expect the are of significant weight loss ment any further as she did not all record to review. All the registered nurse (RN)-A on the RN-A stated she would expect the are of significant sustained a coss. RN-A indicated she would staff reweigh the resident for for non-health related significant change in weight. Nutrition (Impaired) Unplanned and Protocol", revised	F 32	25			
	Weight Loss-Clinic September 2012 ic for weight loss idea Assessment and F 1. The nursing sta	al Protocol", revised dentified the following process ntification:					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		245423	B. WING _		09	/15/2016		
	PROVIDER OR SUPPLIER	ITER		STREET ADDRESS, CITY, STATE, ZIP COE 1102 LIBERTY STREET SOUTHEAST CHATFIELD, MN 55923		, 10, 2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 325	format which perm comparisons over 2. As part of the in physician will defin nutritional status (v pertinent laboratory individuals with and significant risk for in high risk residents vomiting, diarrhea, taking medications increasing the risk 3. The threshold fundesired weight of following criteria: a. 1 month-5% with the severe. b. 3 months-7.5% c. 6 months-10% greater than 7.5% c. 6 months-10% greater than 10% in the comparison of the	its readily available time. nitial assessment, the staff and e the individual's current veight, food/fluid intake, and y values) and identify prexia, recent weight loss and impaired nutrition; for example, with acute symptoms such as fever or infection, or those that may be causing or of anorexia or weight loss. For significant unplanned and poss will be based on the reight loss is significant, is severe. Weight loss is significant, greater weight loss is significant, is severe. Will review possible causes of loss with the nursing staff fore ordering interventions. Will estimate calorie, nutrient d, with physician, will identify int's current intake is adequate onal needs. With recent or rapid weight more than a pound a day) the should consider possible fluid ralance as a cause, Fluid in rapid weight loss.	F 32	25				

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION UNG	(X3	B) DATE SURVEY COMPLETED
		245423	B. WING			09/15/2016
	CHOSEN VALLEY CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 325 Continued From page 25 For example:	TER		STREET ADDRESS, CITY, STATE, ZIP 1102 LIBERTY STREET SOUTHEA CHATFIELD, MN 55923		
PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFI TAG		ON SHOULD BE IE APPROPRIAT	
F 334	For example: a. Cognitive or furb. Chewing or sw. c. Pain d. Medication-rele. Environmental f. Increased nee g. Poor digestion h. Fluid and nutrie. Inadequate av. 483.25(n) INFLUEN IMMUNIZATIONS The facility must dethat ensure that (i) Before offering the each resident, or the representative recebenefits and potent immunization; (ii) Each resident is immunization Octobannually, unless the contraindicated or to the immunized during the contraindicated or to the representative has immunization; and (iv) The resident's redocumentation that following: (A) That the resider representative was the benefits and point immunization; and (B) That the resider	nctional decline. allowing abnormalities. ated adverse consequences. I factors. d for calories and/or protein. or absorption. ent loss; and/or ailability of food or fluids. JZA AND PNEUMOCOCAL evelop policies and procedures the influenza immunization, the resident's legal tives education regarding the tial side effects of the offered an influenza the immunization is medically the resident has already been this time period; the resident's legal the opportunity to refuse medical record includes indicates, at a minimum, the tent or resident's legal provided education regarding tential side effects of influenza ent either received the tion or did not receive the		334		10/25/16

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY IPLETED
		245423	B. WING			09/	15/2016
	PROVIDER OR SUPPLIER	TER	•	110	REET ADDRESS, CITY, STATE, ZIP CODE 02 LIBERTY STREET SOUTHEAST HATFIELD, MN 55923		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 334	contraindications or The facility must de that ensure that (i) Before offering th immunization, each legal representative the benefits and po- immunization; (ii) Each resident is immunization, unles medically contraind already been immu (iii) The resident or representative has immunization; and (iv) The resident's r documentation that following: (A) That the reside representative was the benefits and po- pneumococcal imm (B) That the reside pneumococcal imm the pneumococcal imm the pneumococcal imm the pneumococcal imm years following the immunization, unles	refusal. velop policies and procedures ne pneumococcal resident, or the resident's receives education regarding tential side effects of the offered a pneumococcal se the immunization is icated or the resident has nized; the resident's legal the opportunity to refuse nedical record includes indicated, at a minimum, the ent or resident's legal provided education regarding tential side effects of nunization; and ent either received the nunization or did not receive mmunization due to medical refusal. e, based on an assessment ommendation, a second nunization may be given after 5 first pneumococcal se medically contraindicated or resident's legal representative		334			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245423	B. WING		09/1	5/2016
	PROVIDER OR SUPPLIER	TER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1102 LIBERTY STREET SOUTHEAST CHATFIELD, MN 55923	,	J. 2 0.10
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 334	This REQUIREMEI by: Based on interview facility failed to imprelated to the pneur (PCV13) according Centers for Disease residents (R69, R8 vaccination historie Findings include: R69's Immunization indicated the 88 ye Pneumovax on 12/2 evidence he had be since his admission R80's Immunization indicated the 75 ye Pneumovax on 3/12 evidence she had be vaccine since her a 6/17/16. R83's Immunization indicated the 95 ye Pneumovax on 5/6 she had been offer her admission to the R97's Immunization indicated the 86 ye Pneumovax but the was no evidence she PCV13 vaccine sinc 3/16/16.	and document review, the lement a policy and procedure mococcal conjugate vaccine to recommendations by the Control (CDC) for 4 of 5 o, R83 and R97) whose were reviewed. The Record dated 4/12/16, ear old resident received the 3/2008. There was no been offered the PCV13 vaccine in to the facility 4/12/16. The Record dated 6/17/16, ear old resident received the 5/2006. There was no been offered the PCV13 dmission to the facility The Record dated 3/29/16, ear old resident received the 2/2004. There was no been offered the PCV13 dmission to the facility The Record dated 3/29/16, ear old resident received the 2/2004. There was no evidence end the PCV13 vaccine since	F 334	This plan and response to MCS-28 regarding Tag F 334, is written sole maintain certification in the Medical Medical Assistance programs. We to preserve our right to dispute the findings in their entirely should any remedies be imposed. Chosen Valley Care Center will ensithat Influenza and Pneumococcal Immunizations are offered and documented for all residents accordacility policy. Chosen Valley Care Center sepneumococcal Vaccine Policy has reviewed and updated. The Immunization Record for R69 reviewed and he received the PCV vaccination as prescribed by physicoctober 10, 2016. The Immunization Record for R80 reviewed and she received the PCV vaccination as prescribed by physicoctober 10, 2016. The Immunization Record for R83 reviewed and physician stated that did not need PCV13 because her immunization record was already undate. The Immunization Record for R97 reviewed and physician stated that did not need PCV13 because her immunization record was already undate.	ely to re and wish se sure ding to been was 13 cian on was v13 cian on was she p to was	

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '				E SURVEY PLETED
	245423	B. WING			09/	15/2016
	rer		11	02 LIBERTY STREET SOUTHEAST		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	x		3E	(X5) COMPLETION DATE
years of age or older received PCV13 and received one or mo [pneumococcal polyshould receive a do PCV13 should be a after the most received on 9/14/16, at 2:20 (DON) stated the nepneumococcal vaccimplemented in the updated PCV13 vacadministered or offenot been updated. The facility's policy vaccines revised 6/ guidelines for the PCV13 vaccines revised 6/ guidelines for the PCV1	er who have not previously d who have previously re doses of PPSV23 (saccharide vaccine 23] se of PCV13. The dose of dministered at least one year nt PPSV23 dose." p.m. the director of nursing ew guidelines for updating sines had not been facility. The DON verified an excine had not been ered and the facility policy had and procedure for Pneumovax 15/14, did not include the new CV13 vaccine. I CONTROL, PREVENT Itablish and maintain an orgam designed to provide a comfortable environment and development and transmission ction. I Program tablish an Infection Control			All residents who reside at Chosen of Care Center have the potential to be affected by this deficient practice. A residents immunization records we obtained and will be reviewed by the residents physician or nurse practice 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 Octobe 20th, 21st, and 24th, 2016 on our representance of offering and administe the vaccines to our residents. Influenza/PCV13 Audit will be completed to bring or her desidents will be completed and presentance and then quara audits will be completed and presentance.	Valley e Ill ere e tioner nt ation er vised nd the ering leted signee rterly ted at	10/25/16
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From pa years of age or oldereceived PCV13 an received one or mo [pneumococcal polyshould receive a do PCV13 should be a after the most receive On 9/14/16, at 2:20 (DON) stated the ne pneumococcal vaccimplemented in the updated PCV13 vacadministered or offer not been updated. The facility's policy vaccines revised 6/ guidelines for the P 483.65 INFECTION SPREAD, LINENS The facility must es Infection Control Pr safe, sanitary and of to help prevent the of disease and infect (a) Infection Control The facility must es	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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.	PROVIDER OR SUPPLIER VALLEY CARE CENTER	PROVIDER OR SUPPLIER VALLEY CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 28 years of age or older who have not previously received PCV13 and who have previously received neor 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 441 483.65 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	PROVIDER OR SUPPLIER VALLEY CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRICEDED BY TYLLL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 28 years of age or older who have not previously received PCV13 and who have previously received PCV13 and who have previously received one or more doses of PSV23 [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 PSV23 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 updated. The facility's policy and procedure for Pneumovax vaccines revised 6/15/14, did not include the new guidelines for the PCV13 vaccine. All staff will be in-serviced on Octob 20th, 21st, and 24th, 2016 on our representation of the vaccines to our residents. Influenza/PCV13 Audit will be comp by the Director of Nursing or her desweekly for four weeks and then qual audits will be completed and present the vaccines to our residents. Influenza/PCV13 Audit will be comp by the Director of Nursing or her desweekly for four weeks and then quality improvement Meeting for full year. F 441 483.65 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 Hereal Control Program Infection Control Program F 441	PROVIDER OR SUPPLIER VALLEY CARE CENTER

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245423	B. WING			09/-	15/2016
	PROVIDER OR SUPPLIER	TER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 102 LIBERTY STREET SOUTHEAST CHATFIELD, MN 55923		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	in the facility; (2) Decides what poshould be applied to (3) Maintains a reconstruction actions related to in (b) Preventing Spree (1) When the Infect determines that a reprevent the spread isolate the resident (2) The facility mus communicable disefrom direct contact direct contact will tr (3) The facility mus hands after each dinand washing is incorprofessional practice (c) Linens Personnel must hand	ntrols, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective infections. Pad of Infection tion Control Program esident needs isolation to of infection, the facility must in the prohibit employees with a passe or infected skin lesions with residents or their food, if ansmit the disease. It require staff to wash their rect resident contact for which dicated by accepted	F 4	41			
	by: Based on observative review the facility farmulti-use resident of 5 residents (R73 receive blood gluco Findings include:	·			This plan and response to MCS-28 regarding Tag F 441, is written sole maintain certification in the Medica Medical Assistance programs. We to preserve our right to dispute thes findings in their entirely should any remedies be imposed.	ly to re and wish se	
	During observation	of the morning medication			Chosen Valley Care Center ensure	s that	

PRINTED: 10/17/2016 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & N	IEDICAID SERVICES			(<u>JIMB INO.</u>	<u>0938-0391</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRU NG			SURVEY PLETED
	245423	B. WING			09/1	15/2016
NAME OF PROVIDER OR SUPPLIER			STREET ADD	RESS, CITY, STATE, ZIP CODE		
CHOSEN VALLEY CARE CENTER				TY STREET SOUTHEAST D, MN 55923		
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES BT BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	(EAC	ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOUL S-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
blood glucometer to mo At 6:17 a.m. TMA-B ent small tray containing a ball, lancet, and gloves. the procedure to check and then proceeded to completion of the test, glucometer equipment placed it into a plastic to the medication cart. The alcohol wipes, cotton bases 6:22 a.m. TMA-B again the tray, placing the sare R73, a cotton ball, lance onto the tray. TMA-B erconducted a blood glucosame multi-use glucom blood glucose level. Up blood glucose check with the multi-use glucometer and placed it into the biglucose testing supplies observed to set up glucoserved to set	MA)-B utilized a universal position blood glucose levels. Itered R73's room with a blood glucometer, a cotton at TMA-B informed R73 of the blood glucose level perform the test. Upon TMA-B returned the to the medication cart and sub/bin located on top of the tub contained lancets, alls and glucose strips. At was observed setting upone glucometer utilized for et, gloves and a test strip etered R28's room and ose level test with the eter used to check R73's boon completion of the th R28, TMA-B returned er to the medication cart in containing the other as At 6:29 a.m. TMA-B was ometer supplies once and place the supplies on a minto R80's room. blood glucose levels meter she had utilized for as no observation of tuse blood glucometer and F80's blood glucose	F 4	we main designe comforts prevent transmis R73, R8 reviewer infection resident this practive were no TMA-By the propon September All resid affected relates to audit was and fifter monitor potentia All TMA have be properly All staff 20th, 21 Glucose the prop glucome Glucomodel Complete complete comfort transmission of the prop glucome Complete comfort transmission of the comfort transmission of the comfort transmission of the comfort transmissi	was re-educated immediancer way to disinfect the gluember 14, 2016. Idents have the potential to be to infection control. A facilities completed on October seen residents who have on their blood sugars have the factor of the	tions. were for the time of t	

be sanitized between residents and verified she

then quarterly audits will be completed

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245423	B. WING		 	09/1	5/2016
_	PROVIDER OR SUPPLIER	TER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 102 LIBERTY STREET SOUTHEAST CHATFIELD, MN 55923		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	resident use. TMA on the cart containing indicating she would glucometer. When a whether she would disinfect, TMA-B reclarified she was urglucometer required. When interviewed director of nursing (wipe the multi-use go between resident us have bleach. When reusable equipment was provided on 9/1 DON: "Disinfecting Environmental Surffollowing: Equipment it must be place it is stored. Gafter each use using instructions. At this manufacturers instruction glucometer included or super Sani-wipes	the equipment between B pointed to the alcohol wipes ng the glucometer supplies, d utilize them to cleanse the specifically questioned utilize the alcohol wipes to esponded "yes". TMA-B further naware the multi-use d different sanitization. on 9/15/16, at 11:00 a.m. the DON) verified staff should glucometer equipment se with the Sani-wipes which the policy for cleaning the t was requested, the following 15/16, at 11:30 a.m. by the Reusable Equipment and aces", undated, identified the ent: (a) After using reusable the cleaned and returned to the lucometer's must be cleaned g the manufacturers time, the DON verified the fuctions for cleaning the d using a 1:10 bleach solution s. The DON stated the facility these versus bleach solution.	F	141	and presented at the Quality Improving Meeting for one full year.	rement	

F5423024

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	, including the second of the		' '	TIPLE CONS ING 01 - M	(X3) DATE SURVEY COMPLETED		
		245423	B. WING			09/21/2016	
	PROVIDER OR SUPPLIER	TER		1102 LIE	ADDRESS, CITY, STATE, ZIP COI BERTY STREET SOUTHEAST IELD, MN 55923		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 000	Minnesota Departrice Fire Marshal Divisidated 9/21/2016, Common for the found not in substate requirements for part of the following of the fo	e Survey was conducted by the ment of Public Safety, State on. At the time of this survey chosen Valley Care Center was antial compliance with the articipation in at 42 CFR, Subpart fety from Fire, and the 2000 Fire Protection Association 101, Life Safety Code (LSC), g Health Care. I THE PLAN OF OR THE FIRE SAFETY D: RE INSPECTIONS SHAL DIVISION STREET, SUITE 145	K	000			
	DEFICIENCY MUSE FOLLOWING INFO 1. A description of to correct the defice 2. The actual, or put 3. The name and/or	DRRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION: what has been, or will be, done			EPO	C	

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.

Facility ID: 00750

10/13/2016

Electronically Signed

		L. DENTIFICATION NUMBER.		ULTIPLE CONSTRUCTION LDING 01 - Main Building 01		TE SURVEY MPLETED	
		245423	B. WING _		09	/21/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1102 LIBERTY STREET SOUTHEAST CHATFIELD, MN 55923			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
K 000	Chosen Valley Car with no basement. at 3 different times constructed in 197 Type V(111) constructed a Type V(111) constructed a Type II(000) constructed and w V(111) constructed and w V(111) construction changed after reviethat are on hand for Because the originare of the same ty construction type a The facility will be building.	ence of the deficiency. The Center is a 1-story building The building was constructed The original building was and was determined to be of ruction. In 1998, an addition and was determined to be of ruction. In 2001, an addition and was determined to be of ruction. In 2002, a canopy was as determined to be of Type The construction type was ew of the architectural drawings					
K 018 SS=D	fire alarm system of detection and that department notific. The facility has a consum of 72 at the NFPA 101 LIFE SA Doors protecting or required enclosure hazardous areas as those constructions wood, or cap 20 minutes. Clear and floor covering in fully sprinklered	with full corridor smoke is monitored for automatic fire	K 0	18		10/25/16	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	DE CONSTRUCTION 6 01 - Main Building 01	COMPL	
		245423	B. WING		09/21	/2016
	PROVIDER OR SUPPLIE					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 018	open devices that pushed or pulled provided with a mador closed. Duto permitted. Door from the second permitted of steel or with 8.2.3.2.1. Room the second permitted of steel or with 8.2.3.2.1. Room the second permitted open devices that the pushed provided provid	the closing of the doors. Hold the release when the door is are permitted. Doors shall be the doors meeting 19.3.6.3.6 are the doors shall be labeled and other materials in compliance of the doors are prohibited by in all health care facilities. The solid health care facilities are of vertical openings, exits, or shall be substantial doors, such cated of 13/4 inch solid-bonded on the substantial doors are substantial doors and substantial doors are substantial doors.	K 018	The Director of Environmental Smet with Bowman Door and Hard Company on October 5, 2016 to the warped door in room E-205. door is required and Bowman Downard Endouried and Install a new door ensuring latch properly and have the apprenent of the property and have the apprenent of the property and the same door on or before October 20.	dware inspect A new cor and to furnish that it will copriate install the 25, 2016.	
	door closed. Dute permitted. Door f made of steel or with 8.2.3.2.1. Ro CMS regulations 19.3.6.3 On facility tour be on 9/21/2016, ba revealed that the 1.Corridor door of when tested in ro 2. Rooms A107 a	neans suitable for keeping the ch doors meeting 19.3.6.3.6 are rames shall be labeled and other materials in compliance oller latches are prohibited by in all health care facilities. etween 09:00 AM and 01:00 PM sed on observation and interview of findings include: do not latch in the close position from 205. and A110 has doors that do not blocking door from closing.		Environmental Services inspected rooms to ensure that the doors to resident its rooms latch appropriated and upon further appropriately and appropriately appropriately. Door Latch appropriately. Door Latch appropriately appropriately appropriately appropriately appropriately appropriately appropriately appropriately. Boor Latch appropriately appropr	to the sately. The did not ther e beds in venting I m the be the sate and Audit has amittee will y and	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IULTIPLE CONSTRUCTION ILDING 01 - MAIN BUILDING 01		(X3) DATE SU COMPLE	
		245423	B. WING			09/21/2016	
	PROVIDER OR SUPPLIER			11	REET ADDRESS, CITY, STATE, ZIP CODE 02 LIBERTY STREET SOUTHEAST HATFIELD, MN 55923		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
K 018	the (13) residents of This deficient prace Facility Maintenand discovery. NFPA 101 LIFE SAR Required automatic continuously maintenand are in the condition and are in the	ctice could affect the safety of within the smoke compartment. tice was confirmed by the ce Director at the time of AFETY CODE STANDARD c sprinkler systems are rained in reliable operating inspected and tested		018			10/25/16
	9.7.5 This STANDARD Required automate continuously mainted condition and are in periodically. 19.7.5 On facility tour better.	7.6, 4.6.12, NFPA 13, NFPA 25, is not met as evidenced by: tic sprinkler systems are tained in reliable operating nspected and tested 7.6, 4.6.12, NFPA 13, NFPA 25, ween 09:00 AM and 01:00 PM and on observation and interview			On October 6, 2016 the Director of Environmental Services repaired the ceiling tiles in room 115. Ceiling Tile Audit has been developed safety committee will check ceiling tile part of our monthly inspection, and re to our Quality Improvement Meeting fone full year.	es as port	
	revealed that equipolation ceiling tile and per sprinkler head large. This deficient practine (6) residents with the things of the the things of the the theta in the the theta in the the theta in the the the theta in the the theta in the the theta in the the the theta in the theta in the theta in the t	ed on observation and interview oment room 115 has missing netrations around wiring and ye than a 1/4" of an inch. Itice could affect the safety of within the smoke compartment. Itice was confirmed by the ce Director at the time of			one full year.		



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 <u>only a suggestion</u> 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

Chosen Valley Care Center September 29, 2016 Page 2

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

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

Chosen Valley Care Center September 29, 2016 Page 3

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00750	B. WING		00/15	5/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 09/13	0/2010
		1102 I IBF		T SOUTHEAST		
CHOSEN	I VALLEY CARE CEN	IFR	_D, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment 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.					
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 10/13/16

TITLE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00750	B. WING		09/	15/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CHOSE	N VALLEY CARE CEN	IFR	ERTY STREE LD, MN 5592	T SOUTHEAST 23		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 000	Department of Hearyou electronically, is necessary for Starenter the word "correct. You must then State licensure procompletion date, the corrected prior to el Minnesota Department's staff, the following correction that you and identify the date. In addition, a completion that you and identify the date. In addition, a completion that you and identify the date. Minnesota Department State Licensing federal software. Taxisigned to Minnesota Nursing Homes. The assigned tag in column entitled "ID statute/rule out of cursummary Statement and replaces the "T correction order. The findings which are in after the statement, evidence by." Followare the Suggested Time period for Correction Correction for Correct	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the ment of Health. 15, 2016, surveyors of this visited the above provider and tion orders are issued. Our electronic plan of have reviewed these orders, e when they will be completed. Idint investigation for 23015 and was The orders are issued or the state statutes/rules for umber appears in the far left or Prefix Tag." The state ompliance is listed in the ent of Deficiencies" column to Comply" portion of the nis column also includes the nis column	2 000			

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00750	B. WING	·····	09/1	5/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE	•	
CHOSEN	I VALLEY CARE CEN	IFK	RTY STREE .D, MN 5592	T SOUTHEAST 23		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	APPLIES TO FEDE THIS WILL APPEA THERE IS NO REC PLAN OF CORREC	WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE. QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 265		5 Notification of Chg in	2 265			10/25/16
	policies to guide sta physicians, physicia practitioners, and if legal representative member of a reside accident, or death. nursing services, an attending physician development of the	ast develop and implement aff decisions to consult an assistants, and nurse known, notify the resident's or an interested family ent's acute illness, serious. At a minimum, the director of and the medical director or an must be involved in the se policies. The policies must address at least the tion times for:				
		involving the resident which has the potential for requiring on;				
	physical, mental, o example, a deterior	change in the resident's r psychosocial status, for ration in health, mental, or in either life-threatening al complications;				
	example, a need to	ter treatment significantly, for discontinue an existing form adverse consequences, or to f treatment;				

Minnesota Department of Health

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Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00750	B. WING	B. WING		5/2016	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	•		
CHOSEN	CHOSEN VALLEY CARE CENTER 1102 LIB CHATFIE			T SOUTHEAST 23			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE	
2 265	Continued From page 3		2 265				
	resident from the nu	o transfer or discharge the ursing home; or dunexpected resident deaths.					
	by: Based on observati interview the facility of the significant we	ent is not met as evidenced on, document review and staff failed to notify the physician eight loss experienced for 1 of eviewed for nutrition.		Corrected			
	Findings include:						
	that included GERE disease), peptic ulc disease, anxiety an Minimum Data Set R69 with a Brief Inte (BIMS) score of 4 ir impairment and ide with eating with only The nutrition section	on 4/12/16, with diagnoses of (gastroesophageal reflux er, dementia, stage 3 kidney didepression. R69's quarterly (MDS) assessment identified erview for Mental Status adicating severe cognitive ntified he was independently set up assistance needed. In of the MDS identified R69 of pounds and indicated not in the MDS identified R69 of pounds and indicated not in the MDS identified R69 of pounds and indicated not in the MDS identified R69 of pounds and indicated not in the MDS identified R69 of pounds and indicated not in the MDS identified R69 of pounds and indicated not in the MDS identified R69 of pounds and indicated not indicated not in the MDS identified R69 of pounds and indicated not indi					
	and weight tracking sustained a significal admission and more two months (7/1/16 (most current) indice 9/6/16-199.8 pound with a 10% weight I	69's medical record, height R69 was noted to have ant weight loss since e specifically within the past -9/6/16). R69's weight record ated the following weights: is (lbs) which identified R69 loss since admission. hich indicated a 5% weight					

Minnesota Department of Health

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00750	B. WING		09/1	5/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CHOSEN	CHOSEN VALLEY CARE CENTER 1102 LIB CHATFIE			T SOUTHEAST 23		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 265	Continued From pa	ge 4	2 265			
	was seated at the d wheelchair. R69 wa buttered bread slice R69 was observed	on 9/13/16, at 5:09 p.m. R69 lining room table in his as served a lemon bar, 1 e, boiled potatoes and spinach. 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.					
	9/14/16, at 12:00 p. following food items toast slice, hash broturkey sandwich. At dining room it was of bacon, 1/2 piece triangle, none of the consumed approxing the certified dietary.	of the brunch meal on m. R69 was served the s: 2 strips of bacon, 1 buttered own triangle, soup and half a 12:45 p.m. when R69 left the noted he consumed 1/4 piece of toast, 1/2 hash brown a turkey sandwich and had nately 2 bites of soup. When manager (CDM) observed the ell, he did not eat very good.				
	status were as note (1) A dietary note didentified R69 as ar diagnoses as: HTN disease) and CHF (was identified that I (diuretic) medicatio and was at risk for documented as Nowas independent w	ated to to R69's nutritional ad: ated 5/3/16, at 6:16 a.m. a 88 yr old male with (hypertension), KD (kidney (congestive heart failure). It R69 was administered Lasix and de to diagnosis of edema dehydration. R69's diet was Added Salt (NAS) diet. R69 ith eating and intake greater R69 had upper dentures and				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00750	B. WING		09/1	15/2016
	PROVIDER OR SUPPLIER N VALLEY CARE CEN	TFR 1102 LIBE		TATE, ZIP CODE T SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 265	own teeth on lower swallowing problem and height were red inches (5' 10"). (2) A dietary note didentified R69 with advanced demential disease). Medication orders included Last of edema and at risidentified as independentified	jaw. No chewing nor as documented. His weight corded as 230 lbs and 70 atted 6/7/16, at 6:36 a.m. the following diagnoses: falls, a, Stage III KD (kidney ons reviewed on physician's six (diuretic) due to diagnosis of the for dehydration. R69 was endent with eating and intake greater than 75% of his food. Blowing problems; weight a lbs. and weight within usual to identified R69 was at risk with need for NAS diet, due to to body weight (BW) and BMI normal labs. The note onitor intake, weights and more intake, weights and more intake, weights and more intake, weights and a NAS diet related to heart more intake, at the control of meals served and to eat his wife's food, who sat any groom table. The note also would refuse to eat at times go back to room. There were lowing problems identified and eviewed with no changes in s.	2 265			

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00750	B. WING		09/1	15/2016	
	PROVIDER OR SUPPLIER VALLEY CARE CEN	TER 1102 LIBE		STATE, ZIP CODE ET SOUTHEAST 23			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUN CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
2 265	lbs on 9/6/16. The evidence of physicia significant weight lower weight lower the weight loss and weight recorded ware the weight loss and weight recorded ware lated to the admir the CDM stated the monitored but she hoss as a concern. So loss could have been wheelchair. The CD registered dietician facility on 8/4/16 and R69 had not been liany weight loss. When interviewed concerns weight loss and the weight loss and RN-C stated she we weight loss until the was conducted and notified. When interviewed conducted and notified. When interviewed conducted and notified.	medical record lacked any an notification of the	2 265				

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Minnesota Department of Health

-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
		00750	B. WING		09/1	5/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CHOCEN	LVALLEV CARE CEN	1102 LIRE		T SOUTHEAST		
CHOSE	I VALLEY CARE CEN	CHATFIEL	.D, MN 5592	23		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 265	Continued From page 7		2 265			
	loss and stated she record when she was 9/13/16. The RD state staff make her awa but would not commave R69's medica. During interview wit 9/14/16 at 1:46 p.m. expect to be notified significant weight loproceed to request accuracy and look it.	was unaware of R69's weight did not recall reviewing R69's as at the facility on 8/4/16 and ated she would expect the re of significant weight loss nent any further as she did not I record to review. The registered nurse (RN)-A on . RN-A stated she would dif any resident sustained a ss. RN-A indicated she would staff reweigh the resident for for non-health related gnificant change in weight.				
	The facility policy "Condition or Status identified in the Pol shall promptly notify attending physician changes in the resicondition and/or sta Policy Interpretation (1) The nurse superthe resident's attending the resident's attending the resident's attending the resident's attending the resident's attending to A discovery of inc. A reaction to med. A significant chaphysical/emotional/e. A need to alter the treatment significant f. Refusal of treat g. A need to transitreatment center. h. A discharge with	Change in Resident's ", revised September 2013, by Statement; The facility of the resident, his or her and representative of dent's medical/mental atus. In and Implementation: ervisor/charge nurse will notify ding physician or on-call re has been: incident involving the resident injuries of unknown origin. edication ange in the resident's mental condition. The resident's medical attly, ment or medications for the resident to a hospital or mout proper medical authority, notify the physician of changes				

Minnesota Department of Health

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00750	B. WING		09/1	5/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CHOSEN	VALLEY CARE CEN	IFR	RTY STREE .D, MN 5592	T SOUTHEAST 23		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 265 2 565	or improvement in that: a. Will not normally intervention by staff disease-related clin b. Impacts more the health status. c. Requires interdistrevision to the care d. Ultimately is base clinical staff and the Resident Assessment SUGGESTED MET director of nursing the educate nursing state and family of a charcould be conducted the physician in a tichanges in condition could be reviewed a committee meeting TIME PERIOD FOR (21) days. MN Rule 4658.0408	resolve itself without for by implementing standard lical interventions. It is an one area of the residents esciplinary review and/or plan; and sed on the judgement of the equidelines outlined in the ent Instrument [RAI]. THOD OF CORRECTION: The could conduct an inservice to aff when to notify the physician nge in condition. An audit it to ensure nursing staff notify mely manner of significant in. The results of the audits during the quality assurance	2 265			10/25/16
		omprehensive plan of care I personnel involved in the 				
	This MN Requirements	ent is not met as evidenced				

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Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
CHOSEN	I VALLEY CARE CEN	IFK	ERTY STREE LD, MN 559	ET SOUTHEAST 23		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 9	2 565			
	review the facility fa	on, interview and document illed to implement the plan of risk of injury during falls for 1 reviewed for falls.		Corrected		
	Findings include:					
	Minimum Data Set 7/10/16, identified F Mental Status (BIM severe cognition de identified R69 requi staff with toileting a identified R69 had s	on 4/12/16. The quarterly (MDS) assessment dated R69 with a Brief Interview for S) score of 4 indicating a ficit. The MDS further red limited assistance of one and transfers. Also, the MDS sustained 2 or more falls since and sustained minor injuries				
	notes from 4/12/16 that R69 attempted self-cares repeated 9/13/16 at 3:55 p.m R69 was found by schair alarm soundir and recliner. The notattempting to self tr. The interdisciplinary dated 9/14/16, at 8: interventions to incl bedtime and when protestors at all time able for increased schecks while in room minutes for increas cares/dressing assi (7) offer evening capersonal safety alar at bedside and (10)	documented in progress until 9/13/16 which identified self transfers and/or ly since admission. On . a progress note identified staff sitting on his floor, with ng, between his wheelchair ote identified R69 was ansfer without assistance. If the team (IDT) progress note 34 a.m. identified current fall ude: (1) gripper socks at wearing shoes; (2) hip es; (3) door/curtain open as supervision; (4) every 1 hour m; (5) offer toileting (every 30 ed confusion); (6) morning stance at 5:00 a.m5:30 a.m.; res right after supper; (8) m at all times; (9) keep walker place dicem above and below. These were identified on the				

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00750	B. WING		09/1	5/2016
				STATE, ZIP CODE ST SOUTHEAST 23		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	care plan dated 7/2 mobility related to ir impaired balance so history of trans-isch required assistance and R69 utilized a vmobility. During observation 9/13/16, at 5:41 p.m answer the call light enter the bathroom remove R69 away f wheelchair and leav room, R69 immediathe bathroom and a toileting. R69 attenthe chair alarm. At (RN)-A responded the chair alarm. At (RN)-A responded the chair alarm. At (RN)-to responded the chair alarm and entered the roonto the toilet. It was stood in front of the unable to pivot self assistance. When interviewed of stated she had to be aware R69 was at rassistance to toilet. did not have his hip directed by his care. During a subsequent p.m. RN-A stated NR69 and called som stated, "He [R69] is staff definitely need.	1/16 as R69 had impaired acreased weakness and econdary to dementia and demic attacks (TIA's) and ambulation and positioning wheelchair or walker for of a morning cares on an NA-A entered R69's room to and noted R69 attempting to NA-A was observed to rom the bathroom door in his we the room. After staff left the ately wheeled himself back into attempted independent apted to stand which activated 5:45 p.m. registered nurse to the activated alarm sound om and to assist R69 to pivot so observed that when R69 toilet, he was shaky and and sit on toilet without and sit on toilet without on 9/13/16, at 5:50 p.m. NA-A save the room to locate staff to athroom. NA-A stated she was isk for falling and required During this observation R69 protectors attached as a plan. Int interview on 9/13/16, at 6:33 A-A should have stayed with neone to help her. RN-A a huge fall risk". RN-A stated ed more training as it was not R69 alone when staff are	2 565			

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00750	B. WING		09/1	5/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CHOSEN	CHOSEN VALLEY CARE CENTER 1102 LIB CHATFIE			T SOUTHEAST 3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 11	2 565			
	verified when she u cares he did not ha further indicated sh had worn them duri further stated that F the hip protectors of During interview with a.m. she stated the changed to reflect to the use of the hip p	on 9/13/16, at 6:50 p.m. NA-B indressed R69 for bedtime ve his hip protectors on and e was unaware whether he ng the entire shift. NA-B R69 would often refuse to put in. In RN-C on 9/15/16 at 8:56 care plan had just been hat R69 often would refuse rotectors. RN-C verified the ons had indicated that R69				
	should wear hip protectors at all times. No policy related to Fall intervention was received from facility staff.					
	SUGGESTED MET The director of nurs review and revise p to ensuring the care resident is followed designee could dev and develop a mon	THOD OF CORRECTION: sing (DON) or designee could olicies and procedures related e plan for each individual . The director of nursing or relop a system to educate staff itoring system to ensure staff as directed by the written plan				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.0520 Proper Nursing Car	Subp. 1 Adequate and e; General	2 830			10/25/16
	receive nursing car custodial care, and individual needs an	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and				

Minnesota Department of Health

Minnesota Department of Health

STATEMEN	· · · · · · · · · · · · · · · · · · ·		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3)		(X3) DATE SURVEY COMPLETED	
	00750		B. WING		09/1	5/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
CHOSEN	VALLEY CARE CEN	TFR	RTY STREE .D, MN 5592	T SOUTHEAST 23		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETE DATE
2 830	plan of care as des 4658.0405. A nursi of bed as much as written order from t	scribed in parts 4658.0400 and ng home resident must be out possible unless there is a ne attending physician that the in in bed or the resident	2 830			
	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:			Corrected		
	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.					
	notes identified that and/or self-cares re (1) On 9/13/16, at 3 sitting on his floor, to between his wheeld to self transfer with 8/30/16, at 6:55 a.m patio outside the fro	documented and progress: R69 attempted self transfers peatedly as noted: 3:55 p.m. R69 found by staff with chair alarm sounding, chair and recliner; attempting out assistance. (2) On n. R69 was seated on the out door and was attempting to in the facility when his				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00750	B. WING		00/4	E/0016
		00750	2		U9/ I	5/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
		1102 LIBE	RTY STREE	T SOUTHEAST		
CHOSEN	I VALLEY CARE CEN	TED	.D, MN 5592			
	0.114144507.024					
(X4) ID PREFIX		TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI		DATE
		·		DEFICIENCY)		
	0 " 15	10	0.000			
2 830	Continued From pa	ge 13	2 830			
	wheelchair cushion	slipped out of his wheelchair				
		th cushion onto the patio. No				
	injury noted.	in oddinon onto the patie. No				
		:00 p.m. R69's bed alarm was				
		d when staff entered room R69				
		ng on the floor in his room;				
		ng to get ready for bed.				
		:00 a.m. R69's alarm sounded,				
	, ,					
		d R69 was observed sitting on the distribution of his room; attempted to				
		e bathroom by himself.				
		1:30 a.m. a nursing assistant				
		R69 to the toilet with the use				
		ttempted to sit before				
		and was lowered to the floor.				
		:39 a.m. R69's alarm was				
	0.	red at the room R69 was				
		ckwards and land on floor				
		ed abrasions which required				
	treatment.					
		1:30 R69 was walking from				
		oom with use of walker				
		and fell backwards into his				
	bedside table; rece	ived two skin tears -required				
	nursing treatment.					
		12:15 p.m. R69 fell again,				
	toileted without ass					
		3:28 p.m. R29 was found on				
		after returning from the				
	evening meal.					
		: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					
		room; stated he was going to				
	the bathroom.	, J				
		t 8:49 a.m. R69 was found on				
		in front of his recliner.(13) On				
		n. R69 was found sitting on the				

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Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER CHOSEN VALLEY CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 1102 LIBERTY STREET SOUTHEAST CHATFIELD, MN 5923 PROVIDER RAN OF CORRECTION PREFIX (EACH DESCIPERCEDED BY PULL REGULATORY OR LISC IDENTIFYING INFORMATION) 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 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 follet, 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 a 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. RNA-A stated NA-A should have stayed with R69 and called someone to help her. RNA-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.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
CHOSEN VALLEY CARE CENTER			00750	B. WING		09/1	15/2016
CHATFIELD, MN 55923 SUMMARY STATEMENT OF DEFICIENCIES D PROVIDERS PLAN OF CORRECTION (REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDERS PLAN OF CORRECTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE CROSS REFERENCIATE ACTION SHOULD BE CROSS REFERENCIATIVE ACTION SHOULD BE CROSS REFERENCIATION SHOULD BE	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	-	
PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 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 Someone to help her. RN-A stated 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 leaved R69 alone when staff are	CHOSEN	VALLEY CARE CEN	IFK				
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 tolleting. 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 SA-A should have stayed with R69 and called someone to help her. RN-A stated interview on 19/13/16, at 6:33 p.m. RN-A stated SA-A should have stayed with R69 and called someone to help her. RN-A stated finitely needed more training as it was not acceptable to leave R69 alone when staff are	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
When interviewed on 9/13/16, at 6:50 p.m. NA-B verified when she undressed R69 for bedtime	2 830	floor in his room yea at 5:19 p.m. R69 was his bathroom. During observation 9/13/16, at 5:41 p.m answer the call light enter the bathroom remove R69 away f wheelchair and leav room, R69 immediathe bathroom and a toileting. R69 attenthe chair alarm. At (RN)-A responded the chair alarm. At (RN)-A responded	lling for help. (14) On 4/12/16 as found seated on the floor in of a morning cares on an NA-A entered R69's room to tand noted R69 attempting to NA-A was observed to from the bathroom door in his we the room. After staff left the ately wheeled himself back into attempted independent apped to stand which activated 5:45 p.m. registered nurse to the activated alarm sound om and to assist R69 to pivot as observed that when R69 toilet, he was shaky and and sit on toilet without on 9/13/16, at 5:50 p.m. NA-A eave the room to locate staff to athroom. NA-A stated she was isk for falling and required During this observation R69 protectors attached as a plan. Int interview on 9/13/16, at 6:33 A-A should have stayed with meone to help her. RN-A a huge fall risk". RN-A stated ed more training as it was not R69 alone when staff are pt to self transfer.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _		(X3) DATE SURVEY COMPLETED		
		00750	B. WING		09/	15/2016
				TATE, ZIP CODE T SOUTHEAST 3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 830	on the entire shift. It would often refuse to R69's care plan data impaired mobility reand impaired balan history of trans-ischerequired assistance and R69 utilized a mobility. The follow risk included: (1) as walker; (2) one staff socks on at bedtime reach; (4) check eveneds have been medisal of care have assist; (6) offer eveneds have been medisal of care have assist; (6) offer eveneds have been more fusal of care have assist; (6) offer eveneds have been more fusal of care have assist; (6) offer eveneds have been more fusal of care have assist; (6) offer eveneds have been more fusal of care have assist; (6) offer eveneds assist; (6) offer eveneds assist; (6) offer eveneds assist; (7) more function, (8) teach an sitting or laying positions conduct fall assess checking ambulation bowel and bladder diagnoses, endurar status, medications protectors on at all. The interdisciplinary dated 9/14/16, at 85 interventions to include bedtime and when protestors at all times able for increased schecks while in roominutes for increase.	aware whether he had them NA-B further stated that R69 to put the hip protectors on. sed 7/21/16, identified R69 had elated to increased weakness ce secondary to dementia and memic attacks (TIA's) and ambulation and positioning wheelchair or walker for ing interventions to reduce fall esist of one staff to walk with assistance to put gripper e; (3) call light is always within ery 1 hour in room to ensure net and offer toileting; (5) if another staff attempt to ning care right after supper to dependently perform cares and onitor for signs and symptoms insteady balance, poor posture, the symptomic distribution of the symptomic distribution of the symptomic and the symptomic distribution of the symptomic distribution o				

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
7 (IVD I EXIIV	OF COTTLECTION	IDENTIFICATION NOMBER.	A. BUILDING:		CON	LETED
		00750	B. WING		09/1	5/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
CHOSEN	I VALLEY CARE CEN	IFR	RTY STREE .D, MN 5592	T SOUTHEAST 23		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	HOULD BE COMPLET	
2 830	Continued From pa	ge 16	2 830			
	(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.					
	The director of nursidevelop and implementated to supervision. The DON or designall nursing staff relating the quality assessing the properties of the properties of the director of the properties of the propert	THOD OF CORRECTION: sing (DON) or designee, could nent policies and procedures on and preventing an accident. Hee, could provide training for ated to the accident prevention. The ment and assurance erform random audits to				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 900	MN Rule 4658.0529 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			10/25/16
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which				
	without pressure so pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and				

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STATEMEN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED	
	00750		B. WING		09/1	5/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•		
CHOSEN	I VALLEY CARE CEN	TFR		T SOUTHEAST			
040.15	CLIMMA DV CTA		.D, MN 5592		DNI .	0/5)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 900	Continued From pa	ge 17	2 900				
	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.			Corrected			
	Findings include:						
	assessment dated at risk for pressure pressure ulcers at the Assessment (CAA) mild risk for PU sections assistance with bed frequently incontine CAA identified no occoncern and the integration pressure reducing compattress on bed, turbours. However, on	6/26/16, a stage II pressure					
	R9 was noted lying gripper socks on bu heels/feet were not her knees. At 8:33 a (LPN)- A verified R9	on 9/15/2016, at 8:31 a.m. in bed on her back. R9 had at no heel protectors and floated as pillow was under a.m. licensed practical nurse B's heels/feet were not floated a heel protectors on. No heel					

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Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
	00750		B. WING		09/15/2016	
		00750	B. W.I.G		J 09/1	5/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CHOSEN	VALLEY CARE CEN	TED		T SOUTHEAST		
	T		.D, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 18	2 900			
	interventions that in offload R9's heels a turn and reposition or chair and (3) give calorie and protein wound prevention a times per day. The identify the current right ankle nor had use of the heel prot scale for predicting identify the pressure scale assessments	plan dated 6/3/16, identified cluded: (1) staff were to and ankles when in bed, (2) every two hours when in bed e 4 ounces of Resource 2.0 (a dense drink appropriate for and treatment programs) 4 current care plan did not Stage III PU located on the it been updated to reflect the ector. Review of the Braden PU risk dated 6/23/16, did not e ulcer. No further Braden were conducted since 6/23/16 essments (e.g. tissue				
	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					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
	00750		B. WING		09/1	5/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
OLIGOEN	LVALLEY CARE CEN	1102 LIBE	RTY STREE	T SOUTHEAST		
CHOSEN	I VALLEY CARE CEN	CHATFIEL	.D, MN 5592	23		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 19	2 900			
	ankle measuring 1 6/11/16-duoderm (continues to ankle) ankle. 8/27/16-right ankle 9/3/16-right ankle under the under	by 1 cm. colloid dressing) over right ments of ulcer). have open area to right outer measured 0.5 by 0.5 cm. lcer continues and measured n. Stage III (a full thickness aneous fat may be visible but ascle are not exposed. Slough does not obscure the depth of y include undermining and				
	is as follows for the 6/4/16-0.8 cm by 0 pressure ulcer (part involving epidermis and presents as ab crater). Treatment: (NS) apply Aquacel every 3 days and as 6/19/16-0.5 cm by 0 change in treatmen 6/25/16-0.7 by 0.5 change in treatmen 7/2/16-0.8 by 0.9 cr change in treatmen 7/16/16-0.9 by 0.6 Change in treatmen Aquacel and non-act days and prn. 7/23/16-0.8 by 0.8 cm No reassessment of from Stage II to Sta 7/30/16-0.8 cm by Stage III; No chang 8/7/16-0.8 by 0.7 by	right ankle: .8 cm, no depth, Stage II tial thickness skin loss and or dermis. Superficial rasion, blister or shallow cleanse with normal saline and cover with Duoderm s needed (prn). 0.4 cm, no depth, Stage II; No t. cm, no depth, Stage II; No t. n, no depth, Stage II; No				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:) MULTIPLE CONSTRUCTION (X3) DATE COMP		SURVEY LETED	
	00750		B. WING		09/1	5/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CHOSEN	I VALLEY CARE CEN	TFR		T SOUTHEAST		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	. D, MN 559 2	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PRÉFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
2 900	Continued From pa	ge 20	2 900			
	Duoderm and chan 8/14/16-0.8 by 0.8 k Same treatment. 8/20/16-0.5 by 0.5 c Continue same trea 9/3/16- 0.3 by 0.4 b	cover with Aquacel and ge every 5 days and prn. by 0.1 cm depth, Stage III; cm by 0.1 cm depth, Stage III; atment. by 0.1 cm depth, Stage III. cm, no depth, healing, Stage				
	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.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00750	B. WING		09/1	5/2016
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE	-	
CHOSEN	I VALLEY CARE CEN	TFR	RTY STREE .D, MN 5592	T SOUTHEAST 23		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	SUGGESTED MET The director of nurs all residents at risk they are receiving the treatment/services from developing an pressure ulcers. The designee, could condelivery of care; to services are implended pressure ulcer developments are ulcer developments. TIME PERIOD FOR (21) days.	HOD OF CORRECTION: sing or designee, could review for pressure ulcers to assure the necessary to prevent pressure ulcers d to promote healing of the director of nursing or anduct random audits of the tensure appropriate care and thented; to reduce the risk for telopment. R CORRECTION: Twenty-one	2 900			
2 965	-Nutritional Status Subpart. 2. Nutritio must ensure that a which supplies the determined by the c assessment. Subs	nal status. The nursing home resident is offered a diet caloric and nutrient needs as comprehensive resident titutes of similar nutritive value residents who refuse food	2 965			10/25/16
	by: Based on observati review the facility fa weight loss was ide necessary intervent	ent is not met as evidenced on, interview and document illed to ensure a significant ntified and evaluated so the cions could be implemented for previewed for nutrition and cant weight loss.		Corrected		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00750	B. WING		00/1	E/0016
NAME 05.					09/1	5/2016
	PROVIDER OR SUPPLIER	1102 I IBF		STATE, ZIP CODE E T SOUTHEAST		
CHOSEN	I VALLEY CARE CEN	IFR	D, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 965	Continued From pa	ge 22	2 965			
	that included GERE dementia, stage 3 kdepression. R69's c (MDS) assessment Interview for Menta indicating severe condentified he was in only set up assistant section of the MDS 227 pounds and incorproblems.	on 4//12/16, with diagnoses D, peptic ulcer, hypertension, kidney disease, anxiety and quarterly Minimum Data Set identified R69 with a Brief I Status (BIMS) score of 4 ognitive impairment and dependent with eating with nee needed. The nutrition identified R69 with a weight of dicated no nutritional				
	and weight tracking sustained a signific admission and mor two months (7/1/16 indicated the follow 9/6/16-199.8 pound with a 10% weight I 8/1/16-214.0 lbs whince 7/1/2016. 7/1/16-223.0 lbs 5/10/16-224.0 lbs 5/1/16-230.0 lbs 4/14/16-224.0 lbs 4/13/16-225 Lbs	R69 was noted to have ant weight loss since e specifically within the past -9/6/16). R69's weight recording weights: Is (Ibs) which identified R69 oss since admission. Since indicated a 5% weight loss				
	was seated at the converse wheelchair. R69 was buttered bread slice R69 was observed the evening meal.	on 9/13/16, at 5:09 p.m. R69 lining room table in his as served a lemon bar, 1 e, boiled potatoes and spinach. to consume less than 1/2 of R69 was noted to sit at the e period just looking around				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00750	B. WING		09/1	5/2016
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	, , , ,	<u> </u>
CHOSE	N VALLEY CARE CEN	TFR	RTY STREE	T SOUTHEAST 23		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 965	During observation 9/14/16, at 12:00 p. following food items toast slice, hash briturkey sandwich. A dining room it was of bacon, 1/2 piece triangle, none of the consumed approximate certified dietary tray she stated, "We He is like that some Progress notes relastatus were as note (1) A dietary note didentified R69 as and diagnoses as: HTN disease) and CHF was identified that I (diuretic) medication and was at risk for documented as Nowas independent with than 75% of meals own teeth on lower swallowing problem and height were recinches (5' 10"). (2) A dietary note didentified R69 with advanced demential disease). Medication orders and included diagnosis of edema R69 was identified and intake usually of his food. No chemical contents are contents as a disease of the contents and included diagnosis of edema R69 was identified and intake usually of his food. No chemical contents are contents and included and intake usually of his food. No chemical contents are contents and included and intake usually of his food. No chemical contents are contents and included and intake usually of his food. No chemical contents are contents and included and intake usually of his food. No chemical contents are contents are contents and included and intake usually of his food. No chemical contents are contents are contents are contents and contents are contents are contents.	of the brunch meal on .m. R69 was served the s: 2 strips of bacon, 1 buttered own triangle, soup and half a t 12:45 p.m. when R69 left the noted he consumed 1/4 piece of toast, 1/2 hash brown e turkey sandwich and had mately 2 bites of soup. When manager (CDM) observed the ell, he did not eat very good.	2 965			

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00750	B. WING		09/1	5/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 00/1	0,2010
CHOSEN	I VALLEY CARE CEN	TFR		T SOUTHEAST		
		CHAIFIEL	.D, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 965	Continued From pa	ge 24	2 965			
	risk due to diagnose to multiple meds, de BMI high and due to identified staff to me	ote also identified R69 was at es with need for NAS diet, due ue to body weight (BW) and abnormal labs. The note onitor intake, weights and /MD order; notify CDM, RD as				
	7/12/16, at 11:11 a. 227 lbs., provided a failure, consumed 7 that R69 would try t with him at the dinir identified that R69 wand would want to a no chewing or swal	essment/dietary note dated m. identified R69's weight at a NAS diet related to heart 75-100% of meals served and o eat his wife's food, who sat ng room table. The note also would refuse to eat at times go back to room. There were lowing problems identified. vas reviewed with no changes hes.				
	loss other than weig record lacked any e registered dietician	lacked any further ted to dietary status/weight ght recordings. The medical evidence of the physician, or nursing staff evaluated ventions in place related to				
	eat fine and was ab plan interventions in (1) Will continue to (2) Provide with the and describe food a needed. (3) Place things on items and tell him w (4) Take assisted described in the second	ed 7/1/16, identified R69 could ble to feed himself. The care included: feed himself with set up daily. assistive eating devices/table and location on plate if the table that help distinguish where things are if needed. evices on food-related activity t decisions if he declined to				

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00750 B. WING 00/15/2	/2016
00750 B. WING 09/15/2	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
CHOSEN VALLEY CARE CENTER 1102 LIBERTY STREET SOUTHEAST	
CHATFIELD, MN 55923 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(VE)
(XI) ID	(X5) COMPLETE DATE
2 965 Continued From page 25 2 965	
(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 7/11/16. 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.	

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00750	B. WING		09/1	5/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CHOSEN	I VALLEY CARE CEN	TFR	RTY STREE D, MN 5592	T SOUTHEAST 23		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 965	director of nursing should have reported loss and verified the been notified of the she was unaware of the she would not comparise to be notified significant weight lost of the she was unaware of the she was unaware of the she was unaware of the she would not comparise to be notified significant weight loss identificant the she was unaware of	on 9/14/16, at 11:59 a.m. the (DON) verified nursing staff ed/responded to the weight e RD should also have been weight loss. The DON stated of the weight loss. 5 p.m. the RD was contacted was unaware of R69's weight edid not recall reviewing R69's as at the facility on 8/4/16 and ated she would expect the re of significant weight loss ment any further as she did not I record to review. The registered nurse (RN)-A on a RN-A stated she would dif any resident sustained a loss. RN-A indicated she would staff reweigh the resident for for non-health related ignificant change in weight. Nutrition (Impaired) Unplanned al Protocol", revised entified the following process tification: ecognition: If will monitor and document ary intake of residents in a ts readily available	2 965			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE COMP	
		00750	B. WING		09/1	5/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
OHOOEN	VALLEY OADE OEN	1102 LIBE	RTY STREE	T SOUTHEAST		
CHOSEN	VALLEY CARE CEN	CHATFIEL	.D, MN 5592	23		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 965	Continued From pa	ge 27	2 965			
	vomiting, diarrhea, taking medications increasing the risk of 3. The threshold foundesired weight lo following criteria: a. 1 month-5% we than 5% is severe. b. 3 months-7.5 % greater than 7.5% is c. 6 months-10 % greater than 10% is Cause Identification 1. The physician wand fluid needs and whether the resider to meet their nutrition b. For individuals loss (for example, restaff and physician and electrolyte imbated eficits can result in 2. The physician, multidisciplinary team medications that make weight loss, or increfor example: a. Cognitive or fund. Medication-relie. Environmental	fever or infection, or those that may be causing or of anorexia or weight loss. Or significant unplanned and as will be based on the eight loss is significant, greater to weight loss is significant, greater to weight loss is significant, as severe. It will review possible causes of loss with the nursing staff ore ordering interventions. It is estimate calorie, nutrient left, with physician, will identify the current intake is adequate onal needs. With recent or rapid weight more than a pound a day) the should consider possible fluid alance as a cause, Fluid in rapid weight loss. With help of the lam, will identify conditions and any be causing anorexia, easing the risk of weight loss, anctional decline. allowing abnormalities. ated adverse consequences. factors. d for calories and/or protein. or absorption.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00750	B. WING		09/1	5/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CHOSEN	N VALLEY CARE CEN	TFR	.RIY SIREE .D, MN 5592	T SOUTHEAST 23		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 965	Continued From pa	ge 28	2 965			
	administrator, direct dietary services could and procedures for loss. Nursing and das necessary to the weights. The DON dietary staff, could a basis to ensure control of the dietary staff.					
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21390	MN Rule 4658.0800	O Subp. 4 A-I Infection Control	21390			10/25/16
	control program muprocedures which page A. surveillance collection to identify residents; B. a system for control of outbreaks C. isolation and reduce risk of trans D. in-service exprevention and con E. a resident he immunization prograte defined in part 465 procedures of resident the prevention and F. the development of the procedures of resident procedures, including defined in part 4658 G. a system for H. a system for	ealth program including an am, a tuberculosis program as 8.0810, and policies and lent care practices to assist in treatment of infections; ment and implementation of olicies and infection control a tuberculosis program as				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '			SURVEY LETED	
		00750	B. WING	····	09/1	5/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CHOSEN	I VALLEY CARE CEN	IFK	RTY STREE D, MN 5592	T SOUTHEAST 23		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 29	21390			
	by: Based on observati review the facility fa multi-use resident e	ent is not met as evidenced on, interview and document illed to properly disinfect equipment between use for 3, R28, R80) observed to se monitoring.		Corrected		
	Findings include:					
	administration on 9, medication assistant blood glucometer to At 6:17 a.m. TMA-E small tray containint ball, lancet, and glothe procedure to chand then proceeded completion of the teglucometer equipmed placed it into a plass the medication cartial cohol wipes, cotto 6:22 a.m. TMA-B again the tray, placing the R73, a cotton ball, I onto the tray. TMA-conducted a blood glucose level blood glucose chect the multi-use glucose the conduction assistant as a conducted a blood glucose chect the multi-use glucose check the multi-use glucose and the conducted a blood glucose check the multi-use glucose check the multi-use glucose and the conducted a blood glucose check the multi-use glucose check the multi-use glucose and the conducted a blood glucose check the multi-use glucose and the conducted a blood glucose check th	of the morning medication /14/16, at 6:15 a.m. trained at (TMA)-B utilized a universal of monitor blood glucose levels. Bentered R73's room with a graph about glucometer, a cotton wes. TMA-B informed R73 of eck the blood glucose level at to perform the test. Upon est, TMA-B returned the ent to the medication cart and tic tub/bin located on top of an balls and glucose strips. At gain was observed setting up a same glucometer utilized for ancet, gloves and a test strip Bentered R28's room and glucose level test with the cometer used to check R73's. Upon completion of the k with R28, TMA-B returned meter to the medication cart te bin containing the other				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00750	B. WING		00/1	5/2016
					09/1	5/2010
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE I T SOUTHEAST		
CHOSE	N VALLEY CARE CEN	IFR	D, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	glucose testing sup observed to set up again at the med cas small tray and carry TMA-B checked Rutilizing the same gR28 and R73. Ther sanitization of the nequipment prior to level checks. When interviewed a TMA-B was questing glucometer cleaning stated she was away be sanitized between should have wiped resident use. TMA on the cart containing indicating she would glucometer. When whether she would disinfect, TMA-B reclarified she was unglucometer required. When interviewed a director of nursing wipe the multi-use of the was provided on 9/DON: "Disinfecting Environmental Surfollowing: Equipment it must be place it is stored. Gafter each use using the small surfollowing: Equipment it must be place it is stored. Gafter each use using the same provided on surfollowing: Equipment it must be place it is stored. Gafter each use using the same provided on surfollowing: Equipment it must be place it is stored. Gafter each use using the same provided on surfollowing: Equipment it must be place it is stored. Gafter each use using the same provided on surfollowing: Equipment it must be place it is stored. Gafter each use using the same provided on surfollowing: Equipment it must be place it is stored. Gafter each use using the same provided on surfollowing: Equipment it must be place it is stored.	plies. At 6:29 a.m. TMA-B was glucometer supplies once art and place the supplies on a them into R80's room. 80's blood glucose levels lucometer she had utilized for e was no observation of nulti-use blood glucometer R28 and F80's blood glucose on 9/14/16, at 6:35 a.m. oned about multi-use g between residents. TMA-B are the glucometer needed to en residents and verified she the equipment between -B pointed to the alcohol wipes ng the glucometer supplies, d utilize them to cleanse the specifically questioned utilize the alcohol wipes to esponded "yes". TMA-B further naware the multi-use d different sanitization. on 9/15/16, at 11:00 a.m. the (DON) verified staff should glucometer equipment se with the Sani-wipes which the policy for cleaning the t was requested, the following 15/16, at 11:30 a.m. by the Reusable Equipment and aces", undated, identified the ent: (a) After using reusable be cleaned and returned to the lucometer's must be cleaned g the manufacturers at time, the DON verified the	21390			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			A. BUILDING:			
		00750	B. WING		09/1	5/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
CHOSEN	N VALLEY CARE CEN	IFR	RTY STREE .D, MN 5592	T SOUTHEAST 23		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	manufacturers instruction glucometer include or super Sani-wiper utilized the Sani-wiper utilized the Sani-wiper SUGGESTED MET administrator, direction of glucobe educated as necessification control relution to DON or design could conduct audit compliance.	ructions for cleaning the d using a 1:10 bleach solution s. The DON stated the facility bes versus bleach solution. THOD OF CORRECTION: The tor of nursing (DON) could procedures for proper ometors. Nursing staff could bessary to the importance of ated to cleaning glucometors. Hee, along with the pharmacist, its on a regular basis to ensure	21390			
21426	(a) A nursing home maintain a comprel infection control procurrent tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide regarding implements	e provider must establish and nensive tuberculosis ogram according to the most infection control guidelines of States Centers for Disease tion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students, interes. The Department of extechnical assistance intation of the guidelines.	21426			10/25/16

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00750	B. WING		09/1	5/2016
	PROVIDER OR SUPPLIER	1102 LIBI		STATE, ZIP CODE ET SOUTHEAST		
CHOSE	N VALLEY CARE CEN	IFR	LD, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21426	Continued From pa	ge 32	21426			
	by: Based on interview facility failed to scre residents (R28, R69 tuberculosis (TB), of the 2nd step tube for 1 of 5 residents 2 step TST for 2 of This had the potent residing in the facility Findings include: R28 was admitted to Immunization Report 1/20/15 do you war response was, "dorf for me, but you {sicto." No TB screen was submitted for FR69 was admitted to Immunization Report a symptom screen R80 was admitted to Immunization Report 1/20/16, indicated	o the facility 7/13/16. R28's ort for date range 1/1/2015 - I R28 had a 2 step TST on (this was a prior admission.) ated 7/15/16 to the physician had 2 step mantoux done at repeated?" The physician of the have to repeat the mantoux protocol may be you have or 2 step TST documentation		Corrected		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				OATE SURVEY OMPLETED					
		00750	B. WING		09/1	5/2016					
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DDRESS, CITY, STATE, ZIP CODE								
CHOSEN VALLEY CARE CENTER 1102 LIBERTY STREET SOUTHEAST CHATELE D. MN. 55023											
CHATFIELD, MN 55923 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)											
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE COMPLETE						
21426	Continued From page 33		21426								
	Immunization Reported in the Average and Immunization and did results read. R97 was admitted to Immunization Reported a symptom screen During an interview director of nursing (screens for TB had admission for R28, also verified that R completed upon admission and screens and screens and screens and screens for R28, also verified that R completed upon admission and screens are screens for R28, also verified upon admission and did results for the screens for R28, also verified upon admission and did results for the screens for R28, also verified upon admission and did results for the screens for R28, also verified upon admission and did results for the screens for R28, also verified upon admission and did results for the screens for R28, also verified upon admission and did results for the screens for R28, also verified upon admission and did results for R28	othe facility 3/16/16. R97's of the facility 3/16/16. R97 did not have for TB on admission. On 9/14/16, at 2:20 p.m. the facility 3/16/16 at 2:20 p.m. the facility 4/16/16. R97 of the facility 3/16/16. R97 of the facility 3/16/16. R97's of the fac									
	The facility's policy "Tuberculosis, Scredate July 2013, inconsected and symptoms of T documented negation BAMT (blood assay tuberculosis), or Coprevious 12 months (two-step) TST or (admission. If the fire TST will be administical test is read." SUGGESTED MET The director of nurse could review policies the components of monitoring program.	and procedure titled rening Residents for" revised licated "The physician will dmission for possible signs B" and "Any resident without we TST (tuberculin skin test), of for Mycobacterium (R (chest X-rays) within the swill receive a baseline one-step) BAMT upon rest TST is negative a follow-up stered 1 to 3 weeks after the THOD OF CORRECTION: sing (DON) and/or designee and procedures related to the infection control and TB and Facility staff could be a regulations and the two step									

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED							
		00750	B. WING		09/1	5/2016						
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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	TION SHOULD BE COMPLETE THE APPROPRIATE DATE							
21426	Continued From page 34		21426									
	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.											

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