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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: HV5B

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00750

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245423**
2.STATE VENDOR OR MEDICAID NO.
(L2) **925340800**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/20/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **78** (L18)
13.Total Certified Beds **78** (L17)

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Karen Aldinger, Unit Supervisor — 10/28/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Melissa Poepping, Enforcement Specialist — 10/28/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 28, 2021

CMS Certification Number (CCN): 245423

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

Dear Administrator:

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 September 24, 2021 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 28, 2021

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

RE: CCN: 245423
Cycle Start Date: August 19, 2021

Dear Administrator:

On September 10, 2021, we notified you a remedy was imposed. On October 20, 2021 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of September 24, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 25, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of September 10, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 25, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on September 24, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: HV5B

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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(L9)

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2 AOA 3 Other

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FISCAL YEAR ENDING DATE: (L35)
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X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

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17. SURVEYOR SIGNATURE Date :
Lisa Krebs, HFE NE II 10/10/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 10/28/2021 (L20)

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____ 2. Facility is not Eligible
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24. LTC AGREEMENT ENDING DATE
(L25)

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(L27)

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(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
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01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
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00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
September 10, 2021

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

RE: CCN: 245423
Cycle Start Date: August 19, 2021

Dear Administrator:

On August 19, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 25, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 25, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 25, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO

only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by October 25, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Chosen Valley Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 25, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies

(those preceded by a "F" tag), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

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 February 19, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your

hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING _____ B. WING _____	C 08/19/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 8/18/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 8/16/21 through 8/19/21, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5423038C (MN68065, MN67893), with a deficiency cited at F585. H5423039C (MN60599), however NO deficiencies were cited due to actions implemented by the facility prior to survey: The following complaints were found to be UNSUBSTANTIATED: H5423034C (MN75408) H5423035C (MN73093) H5423036C (MN7100, MN71068) H5423037C (MN68082)	F 000		

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

Electronically Signed | 09/20/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution	F 585		9/24/21

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

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F 585	Continued From page 2 of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;	F 585		

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F 585	Continued From page 3 (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow their grievance process for missing personal property for 1 of 1 residents (R63) who reported missing property. Findings include:	F 585	Chosen Valley Care Center policies address the residents□ right to voice grievances to the facility staff or other agencies/entities that hear grievances without fear of discrimination or reprisal. The staff respect and support each resident□s right to express grievances	

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F 585	Continued From page 4 R63's Quarterly Minimum Data Set (MDS) assessment dated 8/1/21, identified R63 had impaired cognition. During an interview on 8/16/21, at 3:20 p.m., R63 indicated staff had lost his bottom teeth and "haven't done a damn thing to fix the problem." R63 further indicated no one had offered to replace them or send him to a dentist to get a new bottom set of dentures. R63 estimated it had been at least 3 months since he last had them and he told staff they were missing. R63 states he is having difficulty with chewing his food and has had weight loss. During observation on 8/17/21, at 8:39 a.m., a nursing assistant approached R63 and asked if he would like his teeth in and R63 did not respond. During interview on 8/17/21, at 9:35 a.m., R63 stated staff lost his bottom denture months ago and haven't done a thing to solve the problem. During interview on 8/17/21, at 9:27 a.m., nursing assistant (NA)-A indicated she wasn't sure if R63 had both upper and lower dentures, but thought only uppers. NA-A indicated she would verify with the nurse and the electronic medical record (EMR) and let me know. During interview on 8/17/21 at 9:43 a.m., NA-A stated R63's bottom dentures are missing currently and a missing belongs form was completed and turned into social services (SS) just now. During interview on 8/17/21, at 11:52 a.m., R63	F 585	such as those about treatment, care, management of funds, lost items, violation of rights, behavior of staff and other residents, as well as any other concerns regarding their stay at the facility. The facility provides instructions to the resident for filing a grievance or complaint and informs them that it can be done anonymously. The facility policy requires that the grievance be promptly addressed and that the resident is apprised of progress toward resolution. A copy of the grievance policy is available to the resident. Compliance with this regulation positively impacts all residents. The facility□s grievance policy including responding to missing items and the Resident Handbook which addresses options for safe storage of valuables were reviewed and found appropriate. At the time of move in, the residents and their representatives are informed of the availability of a key for a drawer with lock in their room and advised of the availability of a resident fund account to deposit cash. The Social Worker will be comparing the residents□ use/possession of dentures, hearing aids, and eyeglasses with the care plan. Any discrepancies will be promptly investigated. During each resident□s interdisciplinary care conference, the resident/legal representative will be asked whether	

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F 585	Continued From page 5 indicated two girls came into his room this morning and searched all over for his lower denture plate. R63 stated he has told them before but they kept telling him his teeth were in his mouth. R63 stated he told them over and over and until this morning no one believed him. During interview on 8/17/21, at 1:12 p.m., NA-B indicated she noticed when R63 was moved down to this wing that his bottom denture plate was missing. NA-B indicated she was on another unit where he was before it closed for remodeling and had informed the nurse. During interview on 8/17/21 at 1:13 p.m., NA-C indicated R63 had not mentioned his missing lower denture plate since the first week he moved to this unit a few months ago at least. During interview on 8/17/21, at 1:20 p.m., SS-A indicated she just received a missing belongings sheet this morning for R63's missing bottom denture plate. SS-A indicated staff were searching for them now and if they aren't found she will notify the family. A "Missing Item" form dated 8/17/21 indicated R63 is missing bottom denture and signed by NA-B. A policy titled "Grievance Policy" dated 10/16 included: - It is the policy of this facility that each resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal.	F 585	there are any concerns regarding missing items. The staff will be reeducated on the importance of reporting any resident concerns regarding missing items during mandatory all staff education meetings held during the week of September 20th, 2021. Resident Number 63 - The Director of Nurses spoke with the resident□s guardian September 13, 2021. According to the guardian, the resident has stated he did not like the lower dentures and does not want them replaced. The guardian confirmed that he was supportive of the resident□s decision not to replace the dentures. To monitor compliance, the Social Worker/Designee will interview all residents or their legal representatives during the next month to determine whether they have concerns about lost items. As part of the quality improvement process, the lost item notification/tracking forms that were completed during the past six months will be reviewed by the social worker to ensure appropriate response to resident reports of lost items. New reports will be monitored for six months by the Social Worker/Designee to ensure appropriate follow up/resolution. If unresolved resident concerns are identified or noncompliance with related regulations and/or facility policies are noted during the monitoring process, additional auditing and staff training will be done. Any concerns with cares and	

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F 585	Continued From page 6 - The facility will ensure prompt resolution to all grievances, keeping the resident and the resident representative informed throughout the investigation and resolution process. - A grievance or concern can be expressed orally to the grievance official or facility staff or in writing using a grievance form which will be located in main dining room, outside Director of Social Services Office. - Any employee of this facility who receives a complaint shall immediately attempt to resolve the complaint within their role and authority. If a complaint cannot be immediately resolved the employee shall escalate that complaint to their supervisor and the facility grievance official.	F 585	services including missing items will continue to be addressed during the resident□s quarterly interdisciplinary care conferences. Compliance will be reviewed during the October 2021 Quality Assurance Committee meeting and ongoing.	
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or	F 623		9/24/21

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F 623	Continued From page 7 discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual	F 623		

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F 623	Continued From page 8 and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a written transfer notice was given to 4 of 5 residents (R7, R66, R22, and	F 623	The practice of Chosen Valley Care Center is to notify the resident and the resident□s representative in writing	

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F 623	Continued From page 9 R38) upon transfer to the hospital. In addition, the facility failed to have a system in place to ensure residents were given written notices upon transfer. This deficient practice had the potential to affect all 69 residents residing in the facility. Findings include R22 R22's quarterly Minimum Data Set (MDS) assessment indicated R22 did not have cognitive impairment. R22's progress note dated 7/30/21, at 7:52 p.m. indicated R22 was transferred to the hospital after staff had discovered severe redness to both upper thighs and hips. R22's progress note dated 8/2/21, at 1:51 p.m. indicated R22 had returned to the facility. R38 R38's admission MDS assessment dated 6/4/21, indicated R38 did not have cognitive impairment. R38's progress note dated 7/5/21, indicated R38 was transferred at 2:00 a.m. to the hospital via ambulance following a fall. R38's progress note dated 7/8/21, indicated R38 had returned to the facility at 10:45 a.m. R7 R7 was transferred to the hospital via ambulance on 7/31/2021, at 6:40 a.m., after R7 fell. R7 returned to the facility on 7/31/21, at 2:15 p.m. R7 was transferred to the hospital via ambulance on 6/22/2021, at 8:58 a.m. for dislodged nephrostomy tube (thin catheter inserted into the	F 623	before a resident is transferred or discharged from the facility and notify them of the reason for the move except when an immediate transfer or discharge is required by the resident□s urgent medical needs. The facility□s policies regarding written resident transfer notices were reviewed and found appropriate. The system for providing transfer notices was reviewed and the task of providing transfer notices has now been specifically assigned to the Business Office Manager/Designee who is aware of the related regulations and facility policies. Compliance with this regulation positively impacts all residents in the facility. Resident number 7 - The resident□s daughter was notified by phone of all resident transfers and reasons for transfer and gave verbal agreement for the transfers on the following dates: 7/31/2021, 6/22/2021, 5/7/2021 and 4/13/2021. Required notices will be provided in the event of any future hospital transfers. Resident number 66 - The resident is alert and oriented and was aware of the reason for her transfer to the hospital on 7/1/2021 and 7/25/2021. Required notices will be provided in the event of any future hospital transfers. Resident number 22 □ The resident was alert and oriented and aware of the	

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F 623	Continued From page 10 kidney to drain urine) and returned to the facility at 4:45 p.m. R7 was transferred to the hospital via ambulance on 4/13/2021, at 1:30 p.m., for blood in urine and was readmitted to the facility on 4/23/2021, at 1:20 p.m. R7 was transferred to the hospital via ambulance on 5/7/2021, at 11:19 a.m. with increased confusion and shortness of breath and returned to the facility on 5/10/2021, at 1:20 p.m. Upon request to review written transfer notice on 8/17/21, at 2:43 p.m., the director of nursing (DON) indicated they did not put anything in writing to the resident or their family. The DON indicated a transfer form went with the resident to the hospital and bed holds were completed by social services but wasn't aware of any written transfer form and questioned if this was a new regulation. During interview on 8/18/21, at 9:04 a.m., the business office manager (BOM), social services manager and DON indicated they were not providing a written statement to the resident and/or their family at time of discharge. The BOM indicated she started her role last September. R66 R66's Admission MDS assessment dated 5/13/2021 indicated R66 had no cognitive impairment. R66 was transferred to the emergency department on 7/1/2021 for cough and shortness	F 623	reason for his transfer to the hospital on 7/30/2021. The resident□s wife was also notified of the transfer and visited the resident at facility prior to his transfer to the emergency department; she met the resident at the hospital. Required notices will be provided in the event of any future hospital transfers. Resident number 38 □ The resident is alert and oriented and was aware of her transfer to the hospital on 7/5/2021 as well as the reason for the transfer. Required notices will be provided in the event of any future hospital transfers. The Compliance and Ethics Committee will assign a member to monitor compliance as part of the routine business/billing office review. Audits of the provision of required notices will be completed monthly for three months and then quarterly for one year. The audit results will also be reviewed quarterly by a member of the Quality Improvement Committee. If noncompliance is noted during the audits, additional auditing and staff training will be done. The audit results will be reviewed during the October 2021 Quarterly Quality Assurance meeting.	

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F 623	Continued From page 11 of breath and returned the same day. R66 was transferred to the emergency department on 7/25/2021 and hospitalized for Acute and Chronic Respiratory Failure. R66 returned to the facility on 7/31/2021. During an interview on 8/19/2021 at 8:45 A.M., R66 stated the facility verbally explained why R66 was being sent to the emergency department but did not provide paperwork that stated the reason behind being transferred to the emergency department. During an interview on 8/19/2021, RN-A stated the facility does not provide a transfer document to the resident explaining why the resident is being transferred, they tell the resident and their representative verbally. Undated facility policy Bed Hold and Return to Facility Policy and Procedure included; indicated that resident and resident representative would be provided with notification of transfer discharge, reason for move, in writing in a language and manner they can understand, Readmission or return to the facility policy, admission standards.	F 623		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition	F 686		9/24/21

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F 686	Continued From page 12 demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to follow individualized care plan interventions to prevent and or minimize the risk for new or worsening pressure ulcer development for 1 of 1 resident (R22) reviewed for pressure ulcers. Findings include: R22's face sheet dated 8/19/21, included diagnoses of Parkinson's disease, diabetes type 2, pressure ulcer of left buttock stage 2, and pressure ulcer of right buttock stage 3. R22's annual Minimum Data Set (MDS) assessment, dated 4/4/21, indicated R22 had intact cognition. The MDS identified R22 required extensive assist of two or more staff members for bed mobility, transfers, and toileting and had functional limitations in range of motion in both lower extremities. The MDS indicated R22 was frequently incontinent of urine and occasionally incontinent of bowel. The MDS also identified R22 was at risk for pressure ulcers, had one stage 3 pressure ulcer that required pressure ulcer care, and R22 did not have a turning/repositioning program. During an interview on 8/16/21, at 5:05 p.m. R22 sat in his wheelchair. R22 was asked if he had	F 686	Based on the resident□s comprehensive assessment, Chosen Valley Care Center staff provide skin care and treatment consistent with professional standards of practice that reflect resident preferences. The facility has policies and procedures for skin care that address the prevention of pressure ulcers/injuries and promote healing of existing pressure wounds. To prevent unavoidable pressure ulcers, the staff will continue to follow the facility□s procedures which include 1) identifying the resident risk for developing a pressure ulcer/injury 2) assessing any pressure ulcers/injuries which are present upon admission 3) evaluating the resident□s specific risk factors and changes in the resident□s condition that may impact the development and/or healing of a pressure ulcer/injury 4) implementing, monitoring and modifying interventions in an attempt to stabilize, reduce or remove underlying risk factors and 5) providing treatment to heal existing pressure wounds and prevent the development of additional pressure ulcers/injuries. Considering the resident□s skin assessment, choices/preferences, clinical condition,	

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F 686	Continued From page 13 pressure ulcers on his bottom, R22 put his head down and closed his eyes. R22 indicated pressure ulcers were a "sore subject". In response to the question if staff repositioned him off his bottom, R22 responded "not so much". R22's wound assessments dated 8/17/21, identified the following: -stage 2 sacral ulcer that measured 0.8 centimeters (cm) length by 0.6 cm in width with area of 0.3 cm; assessment did not identify a depth. -Stage 2 left upper buttock that measured 1.8 cm x 0.6 cm with area of 0.5 cm; 100% of wound covered in slough. R22's physician orders included: -Wound for Sacral area: change dressing daily and as needed. 1) remove old dressing. 2) cleanse wound with normal saline and warm soapy water. 3) Apply Prisma or sheet collagen to wound base and calmoseptine to periwound and redness, 4) Cover with mepliex border or equivalent dressing (order start date 8/6/21) -Wound care orders for maintaining healthy buttock/sacrum skin 1) inspect and clean buttock gently with warm wet wash cloth 2) place a small amount of barrier cream on the buttocks and irritated skin to prevent maceration and breakdown/wounds. 3. Cover with foam padding at bedtime (order start date 8/2/21) R22's care plan dated 8/4/21, included R22 had an open area on coccyx that opened on 11/2/2020. "This is a healing stage 3 ulcer", R22 was followed by wound clinic. The care plan did not identify the 2nd pressure ulcer. Corresponding interventions included: treat	F 686	and physician input, a care plan is developed that includes goals and approaches aimed at healing any existing pressure ulcers/injuries, limiting the effects of skin risk factors, and stabilizing/improving related co-morbidities. An evaluation of each resident□s skin condition, skin risk factors, and tissue tolerance will continue to be completed at the time of admission, readmission from the hospital, quarterly, and with significant changes in condition. The direct care staff are instructed to inform the licensed nurse of any skin problems noted during cares. Observation of skin on all areas of the body is part of the bathing protocol. The facility□s skin care policies and procedures are addressed as part of the new nursing employee orientation process. The facility□s skin care nurse has developed a pressure ulcer repositioning and supportive surfaces monitoring tool to ensure that residents are repositioned according to the result of their skin assessment and the skin-related plan of care. The need for additional/modified supportive/pressure reduction surfaces will be assessed on a routine basis. During mandatory education meetings held during the week of September 20th, 2021, the nursing staff will be reinstructed on the expectation of following the resident□s skin-related plan of care including the importance of following the	

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F 686	Continued From page 14 wound per physician order and keep track of how my wound is healing as directed until it's completely healed and help me with repositioning every one hour if I have not already done so and observe for any reddened pressure areas. During an observation on 8/16/21, at 4:35 p.m. unidentified nursing assistants transferred R22 from bed to wheelchair. At 4:43 p.m. unidentified staff wheeled R22 to the dining room for evening meal. During an observation and interview at 6:32 p.m. R22 sat up in his wheelchair in his room. Nursing assistant (NA)-H stated she was not aware of when the last time R22 was repositioned and would probably lay R22 down around 7:30-8:00 p.m. At 6:35 p.m. R22 stated staff had not repositioned him or checked for incontinence. A continuous observation on 8/17/21, that started at 11:55 a.m. and ended at 2:53 p.m. identified R22 was not repositioned according to the care plan. -At 11:55 R22 was wheeled back to his room by unidentified staff. -At 11:59 a.m. NA-D and NA-E transferred R22 from wheelchair to bed via full body mechanical lift. NA's pulled down R22's pants, checked his brief for incontinence. A large border foam dressing that was not dated covered R22's lower back and coccyx area. NA-D stated the dressing was changed this morning and would ask the nurse to date the dressing. NA's positioned R22 on his back. -At 12:19 p.m. registered nurse (RN)-A dated the dressing. -At 12:21 p.m. R22's lower feet were elevated on	F 686	care plan for timely repositioning. Resident number 22 - The resident has a Stage 2 sacral ulcer and a Stage 2 left upper buttock ulcer which were present upon return from the hospital. On 9/14/2021 the sacral ulcer measured 0.53cm x 0.27cm with area <0.1cm2 and was 99% closed. On 9/7/2021 the ulcer on the left upper buttock was closed with fragile blanchable skin. A tissue tolerance assessment was completed 8/26/2021. On 8/30/2021 resident□s care plan was updated to reflect every two-hour repositioning side to side; avoid lying on back to keep the sacrum offloaded. Use of the air mattress on his bed and a ROHO cushion in the wheelchair will continue. The resident□s skin will continue to be observed during cares and assessed by a licensed nurse at least weekly and more often if necessary. The physician/nurse practitioner will be kept informed of the resident□s skin status. The resident is routinely followed by the wound clinic. To monitor compliance, the repositioning of residents with pressure ulcers will be audited weekly for six weeks by the NAR Supervisor/designee to ensure that the care plan repositioning schedule is being followed and that the appropriate supportive/pressure reduction interventions are in place. The NAR Supervisor will provide the audit results to the Interdisciplinary Team during the	

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F 686	Continued From page 15 pillow and was slightly repositioned to the left side. -From 12:21 to 2:46 p.m. R22 remained in the same position. -At 2:46 p.m. NA-F stated an unawareness of when R22 was last repositioned. NA-F indicated she had just started her shift and no one had reported off when R22 had last been repositioned to her and would have to check with the other evening shift NA. -At 2:47 p.m. NA-F asked NA-G if she was aware when R22 was last repositioned, NA-G stated nobody passed along when R22 was last repositioned and would have to check with RN-A. -At 2:48 p.m. RN-A confirmed she turned him to write the date on the dressing and positioned him more on his left side. RN-A stated then at around 12:55 p.m. "we put him on his back at this time with his feet elevated." RN-A stated R22 was supposed to be repositioned every hour. -At 2:53 p.m. NA-F and NA-G transferred R22 from wheelchair to bed. When asked how often was R22 supposed to be offered repositioning and toileting, NA-F responded every two hours. When NA's turned R22 to remove incontinent brief, brief was observed to be saturated, and area of redness along the left buttock was observed. NA-F stated R22 was "pretty wet." NA-G stated R22 was "usually a heavy wetter though". During a subsequent continuous observation on 8/18/21, that started at 6:43 a.m. and ended at 8:14 a.m. identified R22 was not repositioned in accordance with the care plan. -At 6:43 a.m. R22 sat up in his wheelchair in his room. -At 7:00 a.m. R22 was wheeled down to the	F 686	routine weekly skin meeting. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed during the October Quality Assurance Committee meeting.	

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F 686	Continued From page 16	F 686		

dining room by an unidentified staff member.
-At 8:00 a.m. R22 was wheeled back to his room by speech therapist.
-At 8:14 a.m. R22 was repositioned via full body mechanical.

During an observation on 8/18/21, at 12:12 p.m. R22 laid in his bed. Registered nurse (RN)-A entered R22's room and informed R22 she was going to change his dressing on his bottom. R22 was assisted to roll onto his left side by nursing assistant (NA)-D. RN-A removed the sacral dressing and cleansed the area. RN-A completed the treatment per physician order. RN-A indicated since there was not a dressing to the wound on the left buttock, there was supposed to be one. RN-A left the room to obtain a dressing then cleansed the wound, applied the cream to the wound base with one of her gloved fingers, removed the glove, applied a new glove to right hand, and applied the dressing.

During an interview on 8/18/21, at 12:31 p.m. licensed practical nurse (LPN)-A stated an awareness the dressing to R22's was not in place, stated the NA's had reported the dressing was off, however, they put R22 back in his chair before the dressing could be put on. LPN-A indicated she thought she might have been informed around 10:30-11:00 a.m. but didn't write down the time. LPN-A stated the NA's should have reported the dressing was not in place right away and waited for her to replace the dressing.

During an interview on 8/19/21, at 9:40 a.m. director of nursing (DON) stated R22 should have been repositioned in accordance with the care plan and the NA's should have reported to

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F 686	Continued From page 17 the nurse immediately and waited for the dressing to be reapplied. Facility policy Pressure Ulcer Risk Assessment dated 5/14/19, included: General Guidelines: 1) Pressure ulcers are usually formed when a resident remains in the same position for an extended period of time causing increased pressure or a decrease in circulation that area which destroys soft tissues. 5) Pressure ulcers are often made worse by continual pressure, heat, moisture, irritating substances on the residents skin. Assessment: 4) Because a resident is at risk can develop a pressure ulcer within 2 to 6 hours of the onset of pressure, the at-risk residents need to be identified and have interventions implemented promptly to attempt to prevent pressure ulcers. Interventions: 2. Residents repositioning determined according to results of skin evaluations (Tissue Tolerance Test and Braden Scale).	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the	F 690		9/24/21

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F 690	Continued From page 18 resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure an individualized toileting program was followed for 1 of 1 residents (R22) reviewed for pressure ulcers. Findings include R22's face sheet dated 8/19/21, included diagnosis of Parkinson's disease, pressure ulcer of right buttock, diabetes type 2, and repeated falls. R22's annual Minimum Data Set (MDS) assessment dated 4/4/21, identified R22 was cognitively intact and did not have	F 690	Bowel and bladder function is considered an important part of the resident□s comprehensive assessment and is recognized as having a significant impact on the residents□ quality of life. The goal of Chosen Valley Care Center staff is that a resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. Based on the resident□s comprehensive assessment, the Chosen Valley Care Center staff ensures that a resident who	

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F 690	Continued From page 19 rejection/refusal of care behaviors. The MDS identified R22 required extensive assistance from two or more staff for transfers and personal hygiene. The MDS indicated R22 was frequently incontinent of urine and occasionally incontinent. R22's mobility care plan dated 8/17/21, instructed staff to use a full body mechanical lift for transfer and toileting. R22's toileting care plan dated 12/17/20, "I am on a toileting program: help me to toilet upon rising, every 2 hours, at bedtime and prn [as needed]. Offer toileting at 4 am. Toilet before brunch, after brunch and after support and after outings. Offer toileting at 11pm, NOCS [over night shift] to check on rounds and toilet as needed. I would like to wear incontinent protection for dignity purposes. Ensure my urinal is within reach." R22's Bladder Assessment dated 5/19/2020, identified R22's Treatment Program as "scheduled toileting/habit training. During an interview on 8/16/21, at 5:06 p.m. R22 sat in his wheelchair in his room. R22 had poor voice quality, spoke in soft tone and did not annunciate words, R22 was difficult to understand. R22 would answer question yes or no with "thumbs up" for yes, "thumbs down" for no. During an observation on 8/17/21, at 11:55 a.m. R22 was wheeled back to his room by unidentified staff member. At 11:59 a.m. nursing assistant (NA)-D and NA-E entered R22's room and hooked him up to the full body mechanical lift. NA's transferred R22 from his chair to his bed. Once R22 was in bed, NA's assisted R22 to	F 690	is incontinent of bowel and/or bladder is identified and assessed with the subsequent development of an individualized plan of care that includes interventions to achieve or maintain as much normal bowel and bladder function as possible. The policies and procedures for assessing urinary/bowel function and managing incontinence were reviewed and found appropriate. During the mandatory educational meetings held during the week of September 20th, 2021, the nursing staff will be instructed on the importance of following the resident□s preference for toileting options and toileting the resident in a timely manner following his/her toileting plan of care. During mandatory staff meetings, the direct care staff will be instructed on the importance of respecting the resident□s toileting preferences and following the resident□s bowel/bladder management care plan. The bowel/bladder function of resident number 22 is being reassessed. The resident□s voiding pattern will be monitored for three days after which the data will be analyzed by a registered nurse. The care plan will then be reviewed by the nurse and interventions will be revised as necessary to promote continence and manage incontinence. Maximizing his ability to self-manage his bowel/bladder program, providing toileting according to the resident□s preference to	

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F 690	Continued From page 20 roll back and forth to check his incontinent garment; NA-D stated R22 was dry. NA's then positioned R22 in bed, washed their hands and exited R22's room without asking and/or attempting to toilet R22. During an observation on 8/17/21, at 2:53 p.m. NA-F and NA-G entered R22's room. NA-G informed R22 she was going to check R22's incontinent brief. NA stated R22 was pretty wet. NA's then performed incontinent care for R22. Neither NA's asked R22 if he wanted to go to the toilet/use bedpan/and/or urinal. NA-G stated they did not offer to take R22 to the bathroom because he had Parkinson's disease, he was a full body mechanical lift, and it hurt him to sit on the toilet. When R22 was asked what his preference was for toileting, R22 pointed to the bathroom, stated did not prefer bed pan, and when asked if it hurt to sit on the toilet, R22 put his thumb down indicating "no". During an interview on 8/19/21, at 9:40 p.m. director of nursing (DON) stated she expected staff to follow care plans for individualized toileting programs. Facility Urinary Incontinence-Clinical Protocol dated 4/2018 included: The staff will identify environmental interventions and assistive devices that facilitate toileting. As appropriate, based on assessment of the category and causes of incontinence, the staff will provide scheduled toileting, prompted voiding, or other interventions to try to improve the individuals continence status.	F 690	the greatest extent possible and providing timely toileting/incontinent care will continue to be the goal. The resident□s current toileting plan of care has been reviewed and found appropriate; the plan will be revised as needed based on the ongoing bowel/bladder assessments. The social worker will inquire about the resident□s satisfaction with toileting-related cares during one-to-one visits. To monitor compliance, for three months, the Director of Nursing/Designee will monitor the records of new admissions to ensure initial urinary and bowel assessments have been completed. For two weeks the Nursing Assistant Supervisor/Designee will randomly audit the staff timeliness of resident toileting assistance. If bladder/bowel assessments are not completed according to facility policy and toileting assistance is not provided to the resident□s plan of care, additional auditing and staff training will be done. The residents□ bowel/bladder function and toileting needs and preferences will continue to be assessed quarterly and reviewed during the quarterly interdisciplinary care conferences with care plan revisions as needed. Compliance will be reviewed during the October 2021 Quality Assurance Committee meeting.	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records	F 755		9/24/21

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F 755	Continued From page 21 CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure physician ordered medication was available for administration in	F 755	Chosen Valley Care Center provides pharmaceutical services to meet the needs of each resident. The facility has a	

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F 755	Continued From page 22 accordance with physician orders for 1 of 3 residents (R6) reviewed for medication administration. In addition, the facility failed to ensure a system for periodic reconciliation of controlled substance medications in 2 of 2 emergency kits (E-Kit) to prevent potential loss or diversion. Furthermore, a controlled substance located in the refrigerator was not double locked. This had the potential to affect the residents present in the facility, who may require controlled medications from the E-Kits. Findings include R6's face sheet dated 8/19/21, indicated R6 had diagnosis of chronic pain. R6's annual Minimum Data Set (MDS) assessment dated 5/23/21, indicated R6 did not have cognitive impairment. The MDS identified R6 was administered ointments/medications to places other than to feet and frequently had pain. R6's physician orders included: Aspercreme with lidocaine cream 4%, apply to both legs topically two times a day for pain. Apply from toes up to and including thighs AND apply to both legs topically as needed for pain an additional two times a day (start date 10/2/2020) R6's medication administration record (MAR) identified the morning doses of Aspercreme on 8/10 and 8/11/21, were not administered. Corresponding progress note dated 8/10/21 at 2:45 p.m. identified the medication was not administered because the cream was "Not available." The progress note dated 8/11/21 at 1:20 p.m. identified the cream was not	F 755	contract with a licensed consultant pharmacist who collaborates with facility staff to coordinate pharmaceutical services and guide the development and implementation of related procedures to ensure the accurate acquiring, receiving, dispensing, storing and administering of all drugs and biologicals. Drugs and biologicals are labeled in accordance with currently accepted professional standards, and include the appropriate accessary and cautionary instructions, and the expiration date when applicable. Compliance with this regulation positively impacts all residents in the facility. The policies related to the storage and reconciliation of medication contained in the emergency medication kit have been reviewed and revised. The Director of Nursing worked with the Medical Director, Pharmacist, and Consultant Pharmacist to ensure that the procedures complied with related regulations. The emergency use of IM Ativan will be discontinued due to the need to refrigerate the medication; IM Medazolam will be substituted. New locks have been installed on the refrigerators in the locked medication room to ensure the secure storage of controlled substances. Controlled substances in the emergency medication kit will be separated from the non-controlled substances. A new medication reconciliation log has been developed for the nurses to record the tamper proof seal number on the	

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F 755	Continued From page 23 administered because "no cream available". During an interview on 8/17/21, at 8:45 a.m. R6 stated she could not remember if she had always gotten her pain creams applied per the doctors order. Facility pharmacy was called on 8/18/21, at 2:24 p.m. Pharmacy representative (PR)-A stated the pharmacy had received the refill request for R6's Aspercreme on 8/7/21 and delivered to the facility the afternoon of 8/11/21. PR stated 8/7/21, was a Saturday and the facility did not identify that the medication was needed urgently or emergently, therefore the medication was not immediately filled. PR stated because the resident did run out of the medication the pharmacy started sending three bottles at a time instead of only one. During an interview on 8/18/21, at 2:40 p.m. director of nursing (DON) confirmed R6 had run out of the Aspercreme medication; facility had ordered the medication however, had not received it from pharmacy until 8/11/21. DON indicated she had arranged for more bottles to be delivered at a time because of the amount R6 required daily. DON indicated the dose that was charted in the evening on 8/10/21, was documented in error. DON indicated she would have expected staff to follow-up with the pharmacy if the medication was not available for administration at schedule times and the provider be notified. On 8/18/21, at 2:25 p.m. a tour of the medication room containing the E-Kit medication storage	F 755	controlled substances emergency kit. When the controlled substance emergency medication kit is opened and a medication used, the nurse opening the kit will apply a new seal and record the number removed and reapplied on the usage sheet faxed to pharmacy. The pharmacy will replace the entire controlled substance emergency medication kit with a new kit by the following business day and notify Director of Nursing immediately of any discrepancies. The policies and procedures addressing medications refills were reviewed and found appropriate. The nurses and trained medication aides will be reeducated during mandatory all staff education meetings held during the week of September 20th, 2021 on the need to request medication refills in a timely manner and to notify the pharmacy when the need for a medication is an emergency/urgent situation using the after-hours pharmacy number when necessary. Resident number 6 □ For pain control, the resident uses a large amount of Aspercreme. To ensure that Aspercreme is readily available for the resident, effective 8/11/2021 the pharmacy will send three jars instead of the one jar sent previously. The staff will request refills in a timely manner to ensure an uninterrupted supply of Aspercreme.	

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F 755	Continued From page 24 cabinet was conducted with licensed practical nurse (LPN)-A. The E-Kit was found to contain controlled substances that are used for pain and anxiety. LPN-A indicated the facility staff do not verify the kit is secured or verify the 4 green tags securing the E-kit are verified. LPN-A indicated if they use a medication from the kit they fill out a sheet of paper included in the kit and send it to the pharmacy who then sends the medication to the director of nursing (DON) who replaces it. LPN-A further indicated if they open the kit, there are new green tags present inside to re-secured the kit. In addition, the refrigerator, unlocked and in the medication room included injectable Ativan (a controlled medication used to treat anxiety) that was in a clear plastic case, secured with a numbered green tag sitting on the shelf. The LPN-A indicated they do not have a process to verify the medication is still secured or present. LPN-A indicated the pharmacy is responsible for that or the director of nursing when she replaces the medication that is used or taken out of the kit. Interview with the director of nursing (DON) on 8/18/21, at 2:45 p.m. confirmed the E-kits contained controlled substances and are not reconciled or monitored by facility staff. The DON indicated the pharmacy is responsible for that. On 8/19/21, at 8:30 a.m., the DON indicated she spoke to the pharmacist regarding the E-kits and the pharmacist indicated the facility is not responsible for the E-kits as they are the property of the pharmacy and not the facilities responsibility. Attempted to contact the	F 755	Compliance will be monitored by the Director of Nurses/Designee through audits of the emergency medication reconciliation log weekly for four weeks to ensure that use of the medications in the emergency kit are reconciled according to policy. The Director of Nurses/Designee will audit the medication carts weekly for four weeks to ensure the adequate supply of medications. If noncompliance is noted, additional auditing and staff education will be done. Compliance will be reviewed during the October 2021Quality Assurance Committee meeting.	

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F 755	Continued From page 25 pharmacist who was out of the office. Review of the facility's Controlled Substance policy effective 4/1/2019 included: - Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal and record keeping in the facility, in accordance with federal and state laws and regulations. - The director of nursing and the consultant pharmacist in collaboration maintain the facility's compliance with federal and state laws and regulations in the handling of controlled medications. Only authorized licensed nursing and pharmacy personnel have access to controlled medications. - Accurate accountability of the inventory of all controlled drugs is maintained at all times. When a controlled substance is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR). - Date and time of administration (MAR, Accountability Record). - Amount administered (Accountability Record) - Remaining quantity (Accountability Record) - Initials of the nurse administering the dose, completed after the medication is actually administered (MAR, Accountability Record).	F 755		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	F 757		9/24/21

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F 757	Continued From page 26 drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, and document review the facility failed to offer and/or attempt non-pharmacological interventions prior to the administration of as needed (PRN) opioid pain medications for 2 of 5 (R47 and R66) reviewed for unnecessary medications. Findings include R47's face sheet dated 8/19/21, included diagnoses of chronic pain syndrome, abnormal results of liver studies, major depressive disorder, end stage renal failure, and generalized epilepsy. R47's annual Minimum Data Set (MDS) assessment dated 7/18/21, indicated R47 did not	F 757	The goal of Chosen Valley Care Center staff is to ensure that each resident□s drug regimen is free from unnecessary drugs. Unnecessary drugs are those used in excessive dose, for excessive duration, without adequate monitoring, without adequate indication for its use, or in the presence of adverse consequences which indicate the dose should be reduced or discontinued. The facility□s policies and procedures for administering as needed (PRN) medications to treat pain were reviewed and revised. A program will be added to the PointClickCare electronic medication administration record that prompts the	

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F 757	Continued From page 27 have cognitive impairment and for activities of daily living required extensive assistance from one staff member. The MDS identified R47 had pain, received scheduled and PRN pain medications, and utilized non-medication interventions for pain. The MDS also identified R47 was administered opioid pain medications. R47's physician orders for pain medications included: -Oxycodone (opioid pain medication) 5 mg (milligrams) one time a day for moderate pain (pain rated 4-7 out of 10); severe pain (rated 8-10) and every 4 hours as needed for chronic pain/non acute pain (start date 12/29/20) -Acetaminophen-codeine 300/30 mg (opioid pain medication) give two tablets five times a day related to chronic pain syndrome (start date 12/29/21) -Fentanyl patch (opioid pain patch) 100 mcg/hr (micrograms/hour) apply patch transdermally [to skin] one time a day every three days for chronic pain syndrome (start date 5/26/21) R47's Pain assessment dated 7/29/21, indicated R47 was able to report presence, location, and characteristics of pain. The assessment indicated R47 had mild pain daily that increased with movement and transfers; pain was relieved with rest, relaxation, and as needed pain medications. The assessment identified R47's individualized non-pharmacological interventions for relieving pain were: relaxation, massage, and distraction. R47's pain care plan dated 7/12/18, indicated R47 may experience pain or discomfort related to history of left femur fracture, recurrent right septic hip and debility related to chronic pain.	F 757	nurse to document the nonpharmacological intervention(s) attempted prior to administration of a PRN analgesic. The PointClickCare software also prompts the nurses to document the effectiveness of the medication. The nurses/trained medication aides will be educated on the revision to the medication administration documentation procedures during mandatory all staff education meetings held the week of September 20th, 2021; the importance of attempting nonpharmacological interventions for pain relief prior to administering PRN analgesics will be reinforced. Resident 47 □ The resident□s pain regimen was reviewed during the physician visit 9/15/2021. Prior dictations address her pain and pain management plan regularly. The resident is very self-directed with her pain management program and informs the physician of her preferences and the physician complies as much as possible because of her challenging behaviors and very strongly stated preferences. With the goal of resident-centered care, the physician often changes her pain medications in an effort to comply with her preferences and maximize comfort. The effectiveness of the resident□s pain management plan will continue to be reassessed on a routine basis and the plan of care will be updated as necessary.	

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F 757	Continued From page 28 Associated pain interventions included, "help me try some non-drug pain relief techniques: neutral body alignment and positioning, linens smooth and comfortable, reminiscing and relation techniques. Provide instruction/demonstration as necessary (date 3/5/2015)". Other interventions included: evaluate the nature of pain and administer pain medication as ordered and determine if working. R47's August medication administration record (MAR) was reviewed in conjunction with progress notes; R47's record lacked location or characteristics of pain and lacked evidence of non-pharmacological interventions prior to administration of PRN pain medication. The following are examples: -R47's MAR on 8/12/21, at 7:57 p.m. oxycodone 5 mg was administered for pain rated 8/10. Corresponding progress note indicated oxycodone was administered with no other information pertaining to R47's pain. -R47's MAR on 8/15/21, at 11:40 a.m. oxycodone 5 mg was administered for pain rated 9/10. Corresponding progress note indicated oxycodone was administered with no other information pertaining to R47's pain. -R47's MAR on 8/16/21, at 11:40 a.m. oxycodone 5 mg was administered for pain rated 9/10. Corresponding progress note indicated oxycodone was administered with no additional information about R47's pain. -R47's MAR on 8/18/21, at 12:40 a.m. oxycodone 5 mg was administered for pain rated 10/10. Corresponding progress note included, "requested to [sic] pain all over"; no other information pertaining to pain and/or interventions was included.	F 757	Resident 66 - The resident□s pain regimen was reviewed during by the nurse practitioner 9/2/2021 visit. Heat therapy to her shoulders was ordered PRN but she is choosing not to utilize the heat therapy. The resident is utilizing the PRN oxycodone every six hours 1-2 times per day mostly at late night or early morning. September 16, 2021, communication to the MD requested another review the resident□s pain regimen with consideration given to scheduling oxycodone at hour of sleep with one additional PRN dose as well as scheduling/encouraging a warm pack to shoulders/lower back at hour of sleep. The effectiveness of the resident□s pain management plan will continue to be reassessed on a routine basis and the plan of care will be updated as necessary. Compliance will be monitored by the Director of Nursing/designee through review of the electronic medication administration records weekly for three weeks for residents receiving PRN analgesics to ensure nonpharmacological interventions were offered before administration of the PRN analgesic. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed during the October 2021 quarterly Quality Assurance Committee meeting.	

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F 757	Continued From page 29 -R47's MAR on 8/18/21, at 1:06 p.m. oxycodone 5 mg was administered for pain rated 9/10. Corresponding progress note indicated oxycodone was administered with no additional information pertaining to R47's pain. During an interview on 8/18/21, at 7:13 a.m. licensed practical nurse (LPN)-B reviewed R47's record and confirmed documentation of location of pain was not identified; LPN-B stated R47 reports her pain is all over. LPN-B stated an unawareness if R47's pain was related to muscle or joint pain. LPN-B indicated the record also did not identify if non-pharmacological interventions were attempted or offered. LPN-B indicated R47 typically was not willing to attempt non-pharmacological interventions and only wanted her pain pill, however stated the refusals should be documented. During an interview on 8/19/21, at 9:18 a.m. director of nursing (DON) reviewed R47's record, DON verified inconsistent documentation of pain location and non-pharmacological interventions attempted/offered. DON stated ideally there would be documentation of pain location and non-pharmacological interventions used or attempted. R66's face sheet indicated diagnoses of other chronic pain, pain in right shoulder and low back pain. R66's quarterly MDS dated 8/7/2021 indicated R66 required one person physical assist with dressing, bathing and transfers and had a	F 757		

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F 757	Continued From page 30 functional limitation in range of motion on one side of upper extremity. R66's physician order for medication included the following: -Oxycodone (narcotic pain medication) 5 mg Give 0.5 tablet every 6 hours as needed for chronic pain. -Acetaminophen 500 mg Give 2 tablets every 6 hours as needed for mild to moderate pain. -Diclofenac Sodium Gel 1% (pain relief cream) Apply to areas of pain topically four times a day for mild to moderate pain -Gabapentin 100 mg Give 1 capsule two times a day for pain. -Lidocaine patch 5% Apply to shoulder topically two times a day for shoulder pain. R66's pain evaluation dated 8/10/2021 indicated R66 experiences mild pain less than daily that increased with right upper extremity movement and increased activity; pain was relieved with medication, rest and compression. The evaluation further indicated non-pharmacological interventions included physical and occupational therapy and right upper extremity compression. R66's care plan indicated to assist R66 to try some non-drug pain relief techniques such as neutral body alignment and positioning, linens smooth and comfortable, reminiscing and relaxation techniques. R66's August medication administration record (MAR) and progress notes were reviewed and showed R66's record lacked characteristics of pain, location of pain and further lacked evidence of non-pharmacological interventions utilized	F 757		

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F 757	Continued From page 31 prior to administration of as needed (PRN) pain medication. The following are examples: -R66's MAR on 8/13/21, at 7:40 P.M., oxycodone 2.5 mg was administered for pain rated 8/10. Corresponding progress note indicated oxycodone was administered with a follow up pain scale of 5/10 with no other information pertaining to R66's pain. -R66's MAR on 8/14/21, at 2:11 A.M., oxycodone 2.5 mg was administered for pain rated 5/10. Corresponding progress note indicated oxycodone was administered with no follow up pain scale and no other information pertaining to R66's pain. -R66's MAR on 8/14/21, at 9:57 P.M., oxycodone 2.5 mg was administered for pain rated 6/10. Corresponding progress note indicated oxycodone was administered with no follow up pain scale and no other information pertaining to R66's pain. -R66's MAR on 8/15/21, at 9:19 P.M., oxycodone 2.5 mg was administered for pain rated 6/10. Corresponding progress note indicated oxycodone was administered with no follow up pain scale and no other information pertaining to R66's pain. -R66's MAR on 8/17/21, at 9:42 P.M., oxycodone 2.5 mg was administered for pain rated 6/10. Corresponding progress note indicated oxycodone was administered with no follow up pain scale and no other information pertaining to R66's pain. During an interview on 8/18/21, at 12:16 P.M., LPN-A stated staff try to suggest non-pharmacological interventions such as massage, heat, ice or elevation but R66 often refuses. LPN-A also stated staff are to document	F 757		

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F 757	Continued From page 32 in a progress note what interventions were offered and if R66 refused. Facility policy Administration procedures for all medications dated 4/1/2019, included: When administering an "as needed" (PRN) medication document reason for giving, observe medication actions/reactions and record on the PRN effectiveness sheet/nurse's notes. Facility Pain Policy dated 6/2/14 included, When pain is identified in a resident staff will identify the location and severity of pain. Staff will document effectiveness of non-pharmacological and pharmacological interventions. Staff will notify physician of resident's pain when: when pain is not effectively treated with non-pharmacological interventions and pharmacological interventions.	F 757		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable	F 880		9/24/21

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F 880	Continued From page 33 diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the	F 880		

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F 880	Continued From page 34 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to perform hand hygiene when performing wound care treatments to reduce the risk and/or prevent infections for 2 of 4 residents (R22 and R38) whose treatments were observed for pressure ulcer and surgical wound care. Findings include: R22's face sheet dated 8/19/21, included diagnoses of diabetes type 2, pressure ulcer of left buttock stage 2, and pressure ulcer of right buttock stage 3. R22's annual Minimum Data Set (MDS) assessment, dated 4/4/21, indicated R22 had intact cognition and had one stage 3 pressure ulcer that required pressure ulcer care. R22's physician orders included: -Wound for Sacral area: change dressing daily and as needed. 1) remove old dressing. 2) cleanse wound with normal saline and warm soapy water. 3) Apply Prisma or sheet collagen to wound base and calmoseptine to periwound	F 880	Chosen Valley Care Center has established and maintains an infection prevention and control program (IPCP) designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of communicable diseases and infections. The infection control program includes 1) identifying, reporting, investigating, controlling, and preventing infections in the facility 2) determining the appropriate procedures, if any, that will be implemented for each resident with an infectious disease and 3) maintaining a record of incidences of infections and tracking any corrective actions taken. The IPCP is reviewed annually and updated as necessary. Antibiotic stewardship and infection control policy changes are reviewed with the Medical Director. The facility□s infections control policies and procedures were reviewed and found appropriate. The policies address a system of surveillance to identify communicable diseases/infections before	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 35 and redness 4) Cover with mepliex border or equivalent dressing (order start date 8/6/21) -Wound care orders for maintaining healthy buttock/sacrum skin 1) inspect and clean buttock gently with warm wet wash cloth 2) place a small amount of barrier cream on the buttocks and irritated skin to prevent maceration and breakdown/wounds. 3. Cover with foam padding at bedtime (order start date 8/2/21) During an observation on 8/18/21, at 12:12 p.m. R22 laid in his bed. Registered nurse (RN)-A entered R22's room and informed R22 she was going to change his dressing on his bottom, R22 consented. R22 was assisted to roll onto his left side by nursing assistant (NA)-D. RN-A washed hands and put gloves on, she then moved the garbage can to the side of the bed. RN-A then took off the gloves and put on new gloves without performing hand hygiene. RN then removed the sacral dressing and cleansed the area. RN-A removed the gloves and put on new gloves without performing hand hygiene and completed the treatment per physician order. RN-A indicated since there was not a dressing to the wound on the left buttock, RN-A had to go get one, RN-A washed her hands then left the room. RN-A returned to R22's room washed her hands and applied gloves. RN-A then cleansed the wound, applied the cream to the wound base with one of her gloved fingers, removed the glove, applied a new glove to right hand, and applied the dressing. RN-A then washed her hands. During an interview on 8/18/21, at 12:28 p.m. RN-A stated she should have performed hand hygiene between glove changes.	F 880	they can spread to other persons in the facility; when and to whom communicable diseases/infections should be reported; standard and transmission-based precautions to be followed to prevent the spread of infections; when and how isolation should be used for a resident; circumstances when an employee with a communicable condition/infection would be prevented from direct contact with residents or food; and hand hygiene after each direct resident contact for which hand cleansing is indicated by accepted professional practice. Compliance with the infection control regulatory requirements and facility policies will positively impact the health and safety of all residents and support them in attaining and maintaining their highest practicable physical, mental and psychosocial well-being. The facility□s policies and procedures for hand hygiene were reviewed and found appropriate. To encourage and better facilitate hand hygiene during dressing changes, additional hand sanitizers will be placed in the resident rooms. During the mandatory all staff education meetings held during the week of September 20th, 2021, the nursing care staff will be instructed on infection control techniques related to dressing changes including the need for hand hygiene between glove changes and after glove removal. Infection control techniques including glove use are addressed during	

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	245423	A. BUILDING _____ B. WING _____	C 08/19/2021

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F 880	Continued From page 36 R38 surgical wound R38's face sheet dated 8/19/21, included diagnoses of acute appendicitis with perforation R38's admission Minimum Data Set (MDS) dated 6/4/21, indicated R38 had intact cognition and had a surgical wound that required surgical wound care. R38's physician orders included Abdomen incision: cleanse with soap and water, apply dry to dry gauze to midline wound two times a day for wound healing (order start date (8/13/21) During an observation on 8/18/21, at 8:09 a.m. R38 laid in bed, licensed practical nurse (LPN)-B entered the room and informed R38 it was time to change her dressing, R38 consented. LPN-B washed his hands then picked up the garbage can and moved it to bed side. Without performing hand hygiene LPN-B put gloves on and removed the gauze cover dressing and the gauze that was packed inside the wound. LPN-B then removed the gloves and without performing hand hygiene, donned new gloves, cleansed the wound, then applied the treatment per physician order. During an interview on 8/18/21, at 8:25 a.m. LPN-B stated he should have had gloves on when moving the garbage can and indicated an unawareness of appropriate hand hygiene between glove changes. During an interview on 8/19/21,a t 9:35 a.m. director of nursing (DON) stated nurse should have performed hand hygiene after touching the garbage can and should have performed hand hygiene after taking gloves off and before putting	F 880	the new employee orientation and are included in the annual mandatory staff training. The nurses who completed the dressing change for residents 22 and 38 without cleansing hands between glove changes have been counseled. During a subsequent return demonstration of a dressing change, the nurses were observed using the correct technique to minimize the risk of infection. Weekly for four weeks the Infection Preventionist/designee will monitor compliance with infection control techniques by direct observation of the staff completing dressing changes with a focus on proper hand hygiene related to glove use during dressing changes. Resident numbers 22 and 38 will be included in the observation sample. If noncompliance is noted, additional observations and staff training will be done. Compliance with infection control policies/techniques will be reviewed during the October 2021 quarterly Quality Assurance Committee.	

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F 880	Continued From page 37 on new gloves. Facility Policy Dressing Change Procedure dated 5/14/2019, included the following: Position resident Wash and dry your hands thoroughly. Put on clean gloves Loosen tape and remove soiled dressing Pull glove over dressing and discard into plastic or biohazard bag. Wash and dry your hands thoroughly Open dressing packages Wash and dry hands thoroughly Put on clean gloves Cleanse the wound with ordered cleanser. Apply the ordered dressing Remove disposable gloves and wash and dry your hands thoroughly. Facility policy Handwashing/Hand Hygiene dated 8/2015 included the following: Use an alcohol based hand rub or soap and water for following situations: before handling clean or soiled dressings, gauze pads, etc. before moving from a contaminated body site to a clean body site during resident care, after contact with blood or bodily fluids, after handling used dressings, contaminated equipment. after removing gloves.	F 880		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 08/19/2021. At the time of this survey, CHOSEN VALLEY CARE CENTER BUILDING 01 was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/20/2021

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Chosen Valley Care Center Building 01 is a 1-story building with no basement. Building 01 was constructed at three different times. The original building was constructed in 1975 and was determined to be of Type V(111) construction. In 1998, an addition was constructed and was determined to be of Type V(111) construction. In 2001, an addition was constructed and was determined to be of Type II(000) construction. In 2002, a canopy was constructed and was determined to be of Type V(111) construction.	K 000		

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K 000	Continued From page 2 The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The building is attached to Building 02, an addition constructed in 2020 which was determined to be of Type V(111) construction. There is a 2-hour fire-rated wall separating the two buildings and will therefore be surveyed as two buildings. The facility has a capacity of 78 beds and had a census of 67 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to prove acceptance of the new fire alarm system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 9.6.1.3, and 19.6.2.7 and	K 345	On 8/19/21 the contracted company was contacted to pull the fire alarm system notification testing report. The report was pulled that same day. A copy of the report was placed in the appropriate binder in	9/20/21

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K 345	Continued From page 3 NFPA 72 (2010 edition) National Fire Alarm and Signal Code, sections 10.8.1. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 08/19/2021 between 09:00 AM to 02:00 PM, it was revealed during documentation review that no documentation or records were presented for review to confirm facility conversion to new fire alarm system panel and testing of the system. This deficient condition was confirmed by the Facility Maintenance Director at the time of discovery.	K 345	the Maintenance Director□s office and will continue to be updated in accordance with requirements. The Quality Improvement Committee will ensure the next testing is completed in the required timeframe and in compliance.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25	K 353		9/20/21

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K 353	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5 and 9.7.7, and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2, 5.2.1.1.1, 5.2.1.1.2, 5.2.1.1.4, 5.2.1.2, and NFPA13 (2010 edition), Standard for the Installation of Sprinkler Systems, sections 8.5.6, 8.5.6.1. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 08/19/2021 between 09:00 AM to 02:00 PM, it was revealed during documentation review that annual sprinkler system annual testing was past due completion, with the latest records being completed on 07/07/2020. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 353	On 9/15/21 the contracted company came to complete annual testing of the sprinkler system. A monitor has been developed to ensure quarterly as well as annual sprinkler maintenance and testing is completed. This has been added to the monthly Safety Committee checks and will be reported to the Quality Improvement Committee for one full year.	
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by:	K 355		9/20/21

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K 355	Continued From page 5 Based on observation and staff interview, the facility failed to maintain accessibility and installation of portable fire extinguishers in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12 and 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 6.1.3.3, 6.1.3.4, 6.1.3.8, 7.2.2. These deficient conditions could have a patterned impact on the residents within the facility. Findings include: 1. On 08/19/2021, between 09:00 AM to 02:00 PM, it was revealed that adjacent to Room 220, there was obstructed access to the fire extinguisher. 2. On 08/19/2021, between 09:00 AM to 02:00 PM, it was revealed there was an unmounted fire extinguisher in Room 220. These deficient conditions were confirmed by the Maintenance Director at the time of discovery.	K 355	On 8/18/21 the unsecured fire extinguisher was removed from the area. The Maintenance Director or designee will conduct monthly fire extinguisher checks and report the results quarterly to the Quality Improvement Committee for one full year.	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of	K 374		9/20/21

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K 374	Continued From page 6 egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.3, 7.2.1.15.2, and 8.5.4, and NFPA 105 (2010 edition), Standard for Smoke Doors and Other Opening Protectives, section 5.1.2, 5.1.4, 5.2.1.2. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 08/19/2021 between 09:00 AM to 02:00 PM, it was revealed that the smoke barrier doors of WING 300, adjacent to Room 310 and Room 212, did not close to resist the spread of smoke. This deficient condition was verified by the Maintenance Director.	K 374	Immediately upon discovery on 8/18/21, the holes were fire caulked. The safety committee will complete quarterly checks of smoke barriers quarterly and report the results quarterly to the Quality Improvement Committee for one full year.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible	K 712		9/20/21

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K 712	Continued From page 7 alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to randomly conduct fire drills in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.7.6. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 08/19/2021 between 09:00 AM to 02:00 PM, it was revealed during documentation review that 90-minute time separation was not met for fire drills conducted on the1st shift during quarters 2, 3, and 4, the 2nd shift during quarters 1, 2, 3, and 4, and the 3rd shift during quarters 2, 3, and 4. This deficient condition was confirmed by the Facility Maintenance Director at the time of discovery.	K 712	The Safety Committee will follow and ensure all fire drills are done on schedule and at varying times to ensure drills are at least 90 minutes apart. The results will be reported quarterly to the Quality Improvement Committee for one full year.	
K 926 SS=F	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 926		9/24/21

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K 926	Continued From page 8 Based on document review and staff interview, the facility failed to confirm the existence of a medical gas qualification and staff training in accordance with the NFPA 99 (2012 edition), Health Care Facilities Code, section 11.5.2.1.1, 11.5.2.1.2, 11.5.2.1.3, and 11.5.2.1.4 This deficient condition could have a widespread impact on the residents within the facility. Findings Include: On 08/19/2021 between 09:00 AM to 02:00 PM, it was revealed during document review that no documentation was presented for review to confirm staff Med Gas training associated with new hire employee in-service or subsequent refresher training. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 926	New education material related to oxygen training was obtained from the facility□s contracted oxygen provider. All nurses and trained medication aids will be re-educated with the new education material during mandatory education meetings held during the week of September 20th, 2021. An audit will be performed to ensure compliance of education annually and upon hire for all nurses and trained medication aids. Results will be reported quarterly to the Quality Improvement Committee for one full year.	

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

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 08/19/2021. At the time of this survey, CHOSEN VALLEY CARE CENTER BUILDING 02 was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18 New Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/20/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING **02 - 102 LIBERTY STREET** B. WING _____	**08/19/2021**

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Chosen Valley Care Center (Building 02) is a 1 story building with no basement. The addition was constructed in 2020 and was determined to be of Type V (111) construction. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection, resident rooms and spaces open to the corridors that are monitored for automatic fire department notification.	K 000		

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K 000	Continued From page 2 The building is attached to (Building 01) a 1-story building with no basement. Building 01 was constructed at 3 different times. The original building was constructed in 1975 and was determined to be of Type V(111) construction. In 1998, an addition was constructed and was determined to be of Type V(111) construction. In 2001, an addition was constructed and was determined to be of Type II(000) construction. In 2002, a canopy was constructed and was determined to be of Type V(111) construction. There is a 2-hour fire rated wall separating the two buildings, and will therefore be surveyed as two buildings. The facility has a capacity of 78 beds and had a census of 67 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to prove acceptance of the new fire alarm system in accordance with NFPA 101 (2012 edition), Life	K 345	On 8/19/21 the contracted company was contacted to pull the fire alarm system notification testing report. The report was pulled that same day. A copy of the report	9/20/21

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K 345	Continued From page 3 Safety Code, sections 9.6.1.3, and 19.6.2.7 and NFPA 72 (2010 edition) National Fire Alarm and Signal Code, sections 10.8.1. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 08/19/2021 between 09:00 AM to 02:00 PM, it was revealed during documentation review that no documentation or records were presented for review to confirm facility conversion to new fire alarm system panel and testing of the system. This deficient condition was confirmed by the Facility Maintenance Director at the time of discovery.	K 345	was placed in the appropriate binder in the Maintenance Director□s office and will continue to be updated in accordance with requirements. The Quality Improvement Committee will ensure the next testing is completed in the required timeframe and in compliance.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.	K 353		9/20/21

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K 353	Continued From page 4 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5 and 9.7.7, and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2, 5.2.1.1.1, 5.2.1.1.2, 5.2.1.1.4, 5.2.1.2, and NFPA13 (2010 edition), Standard for the Installation of Sprinkler Systems, sections 8.5.6, 8.5.6.1. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 08/19/2021 between 09:00 AM to 02:00 PM, it was revealed during documentation review that annual sprinkler system annual testing was past due completion, with the latest records being completed on 07/07/2020. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 353	On 9/15/21 the contracted company came to complete annual testing of the sprinkler system. A monitor has been developed to ensure quarterly as well as annual sprinkler maintenance and testing is completed. This has been added to the monthly Safety Committee checks and will be reported to the Quality Improvement Committee for one full year.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of	K 712		9/20/21

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K 712	Continued From page 5 established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to randomly conduct fire drills in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.7.6. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 08/19/2021 between 09:00 AM to 02:00 PM, it was revealed during documentation review that 90-minute time separation was not met for fire drills conducted on the1st shift during quarters 2, 3, and 4, the 2nd shift during quarters 1, 2, 3, and 4, and the 3rd shift during quarters 2, 3, and 4. This deficient condition was confirmed by the Facility Maintenance Director at the time of discovery.	K 712	The Safety Committee will follow and ensure all fire drills are done on schedule and at varying times to ensure drills are at least 90 minutes apart. The results will be reported quarterly to the Quality Improvement Committee for one full year.	
K 926 SS=F	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment.	K 926		9/24/21

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K 926	Continued From page 6 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to confirm the existence of a medical gas qualification and staff training in accordance with the NFPA 99 (2012 edition), Health Care Facilities Code, section 11.5.2.1.1, 11.5.2.1.2, 11.5.2.1.3, and 11.5.2.1.4 This deficient condition could have a widespread impact on the residents within the facility. Findings Include: On 08/19/2021 between 09:00 AM to 02:00 PM, it was revealed during document review that no documentation was presented for review to confirm staff Med Gas training associated with new hire employee in-service or subsequent refresher training. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 926	New education material related to oxygen training was obtained from the facility□s contracted oxygen provider. All nurses and trained medication aids will be re-educated with the new education material during mandatory education meetings held during the week of September 20th, 2021. An audit will be performed to ensure compliance of education annually and upon hire for all nurses and trained medication aids. Results will be reported quarterly to the Quality Improvement Committee for one full year.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 10, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: HV5B11

Dear Administrator:

The above facility was surveyed on August 16, 2021 through August 19, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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	00750	A. BUILDING: _____ B. WING _____	C 08/19/2021

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/16/2021 through 8/19/21 a survey was conducted to determine compliance for state licensure. The following correction orders are issued. Please indicate your electronic plan of correction that you have reviewed these order, and identify the date when they will be corrected.	2 000		

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2 900	Continued From page 1	2 900		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and 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 follow individualized care plan interventions to prevent and or minimize the risk for new or worsening pressure ulcer development for 1 of 1 resident (R22) reviewed for pressure ulcers. Findings include: R22's face sheet dated 8/19/21, included diagnoses of Parkinson's disease, diabetes type 2, pressure ulcer of left buttock stage 2, and pressure ulcer of right buttock stage 3. R22's annual Minimum Data Set (MDS) assessment, dated 4/4/21, indicated R22 had	2 900	REVIEWED/CORRECTED	9/24/21

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2 900	Continued From page 2 intact cognition. The MDS identified R22 required extensive assist of two or more staff members for bed mobility, transfers, and toileting and had functional limitations in range of motion in both lower extremities. The MDS indicated R22 was frequently incontinent of urine and occasionally incontinent of bowel. The MDS also identified R22 was at risk for pressure ulcers, had one stage 3 pressure ulcer that required pressure ulcer care, and R22 did not have a turning/repositioning program. During an interview on 8/16/21, at 5:05 p.m. R22 sat in his wheelchair. R22 was asked if he had pressure ulcers on his bottom, R22 put his head down and closed his eyes. R22 indicated pressure ulcers were a "sore subject". In response to the question if staff repositioned him off his bottom, R22 responded "not so much". R22's wound assessments dated 8/17/21, identified the following: -stage 2 sacral ulcer that measured 0.8 centimeters (cm) length by 0.6 cm in width with area of 0.3 cm; assessment did not identify a depth. -Stage 2 left upper buttock that measured 1.8 cm x 0.6 cm with area of 0.5 cm; 100% of wound covered in slough. R22's physician orders included: -Wound for Sacral area: change dressing daily and as needed. 1) remove old dressing. 2) cleanse wound with normal saline and warm soapy water. 3) Apply Prisma or sheet collagen to wound base and calmoseptine to periwound and redness, 4) Cover with mepliex border or equivalent dressing (order start date 8/6/21) -Wound care orders for maintaining healthy	2 900		

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2 900	Continued From page 3 buttock/sacrum skin 1) inspect and clean buttock gently with warm wet wash cloth 2) place a small amount of barrier cream on the buttocks and irritated skin to prevent maceration and breakdown/wounds. 3. Cover with foam padding at bedtime (order start date 8/2/21) R22's care plan dated 8/4/21, included R22 had an open area on coccyx that opened on 11/2/2020. "This is a healing stage 3 ulcer", R22 was followed by wound clinic. The care plan did not identify the 2nd pressure ulcer. Corresponding interventions included: treat wound per physician order and keep track of how my wound is healing as directed until it's completely healed and help me with repositioning every one hour if I have not already done so and observe for any reddened pressure areas. During an observation on 8/16/21, at 4:35 p.m. unidentified nursing assistants transferred R22 from bed to wheelchair. At 4:43 p.m. unidentified staff wheeled R22 to the dining room for evening meal. During an observation and interview at 6:32 p.m. R22 sat up in his wheelchair in his room. Nursing assistant (NA)-H stated she was not aware of when the last time R22 was repositioned and would probably lay R22 down around 7:30-8:00 p.m. At 6:35 p.m. R22 stated staff had not repositioned him or checked for incontinence. A continuous observation on 8/17/21, that started at 11:55 a.m. and ended at 2:53 p.m. identified R22 was not repositioned according to the care plan. -At 11:55 R22 was wheeled back to his room by unidentified staff.	2 900		

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2 900	Continued From page 4 -At 11:59 a.m. NA-D and NA-E transferred R22 from wheelchair to bed via full body mechanical lift. NA's pulled down R22's pants, checked his brief for incontinence. A large border foam dressing that was not dated covered R22's lower back and coccyx area. NA-D stated the dressing was changed this morning and would ask the nurse to date the dressing. NA's positioned R22 on his back. -At 12:19 p.m. registered nurse (RN)-A dated the dressing. -At 12:21 p.m. R22's lower feet were elevated on pillow and was slightly repositioned to the left side. -From 12:21 to 2:46 p.m. R22 remained in the same position. -At 2:46 p.m. NA-F stated an unawareness of when R22 was last repositioned. NA-F indicated she had just started her shift and no one had reported off when R22 had last been repositioned to her and would have to check with the other evening shift NA. -At 2:47 p.m. NA-F asked NA-G if she was aware when R22 was last repositioned, NA-G stated nobody passed along when R22 was last repositioned and would have to check with RN-A. -At 2:48 p.m. RN-A confirmed she turned him to write the date on the dressing and positioned him more on his left side. RN-A stated then at around 12:55 p.m. "we put him on his back at this time with his feet elevated." RN-A stated R22 was supposed to be repositioned every hour. -At 2:53 p.m. NA-F and NA-G transferred R22 from wheelchair to bed. When asked how often was R22 supposed to be offered repositioning and toileting, NA-F responded every two hours. When NA's turned R22 to remove incontinent brief, brief was observed to be saturated, and area of redness along the left buttock was	2 900		

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2 900	Continued From page 5 observed. NA-F stated R22 was "pretty wet." NA-G stated R22 was "usually a heavy wetter though". During a subsequent continuous observation on 8/18/21, that started at 6:43 a.m. and ended at 8:14 a.m. identified R22 was not repositioned in accordance with the care plan. -At 6:43 a.m. R22 sat up in his wheelchair in his room. -At 7:00 a.m. R22 was wheeled down to the dining room by an unidentified staff member. -At 8:00 a.m. R22 was wheeled back to his room by speech therapist. -At 8:14 a.m. R22 was repositioned via full body mechanical. During an observation on 8/18/21, at 12:12 p.m. R22 laid in his bed. Registered nurse (RN)-A entered R22's room and informed R22 she was going to change his dressing on his bottom. R22 was assisted to roll onto his left side by nursing assistant (NA)-D. RN-A removed the sacral dressing and cleansed the area. RN-A completed the treatment per physician order. RN-A indicated since there was not a dressing to the wound on the left buttock, there was supposed to be one. RN-A left the room to obtain a dressing then cleansed the wound, applied the cream to the wound base with one of her gloved fingers, removed the glove, applied a new glove to right hand, and applied the dressing. During an interview on 8/18/21, at 12:31 p.m. licensed practical nurse (LPN)-A stated an awareness the dressing to R22's was not in place, stated the NA's had reported the dressing was off, however, they put R22 back in his chair before the dressing could be put on. LPN-A	2 900		

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2 900	Continued From page 6 indicated she thought she might have been informed around 10:30-11:00 a.m. but didn't write down the time. LPN-A stated the NA's should have reported the dressing was not in place right away and waited for her to replace the dressing. During an interview on 8/19/21, at 9:40 a.m. director of nursing (DON) stated R22 should have been repositioned in accordance with the care plan and the NA's should have reported to the nurse immediately and waited for the dressing to be reapplied. Facility policy Pressure Ulcer Risk Assessment dated 5/14/19, included: General Guidelines: 1) Pressure ulcers are usually formed when a resident remains in the same position for an extended period of time causing increased pressure or a decrease in circulation that area which destroys soft tissues. 5) Pressure ulcers are often made worse by continual pressure, heat, moisture, irritating substances on the residents skin. Assessment: 4) Because a resident is at risk can develop a pressure ulcer within 2 to 6 hours of the onset of pressure, the at-risk residents need to be identified and have interventions implemented promptly to attempt to prevent pressure ulcers. Interventions: 2. Residents repositioning determined according to results of skin evaluations (Tissue Tolerance Test and Braden Scale). SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or	2 900		

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2 900	Continued From page 7 designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure an individualized toileting program was followed for 1 of 1 residents (R22) reviewed for pressure ulcers. Findings include	2 910	REVIEWED/CORRECTED	9/24/21

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2 910	Continued From page 8 R22's face sheet dated 8/19/21, included diagnosis of Parkinson's disease, pressure ulcer of right buttock, diabetes type 2, and repeated falls. R22's annual Minimum Data Set (MDS) assessment dated 4/4/21, identified R22 was cognitively intact and did not have rejection/refusal of care behaviors. The MDS identified R22 required extensive assistance from two or more staff for transfers and personal hygiene. The MDS indicated R22 was frequently incontinent of urine and occasionally incontinent. R22's mobility care plan dated 8/17/21, instructed staff to use a full body mechanical lift for transfer and toileting. R22's toileting care plan dated 12/17/20, "I am on a toileting program: help me to toilet upon rising, every 2 hours, at bedtime and prn [as needed]. Offer toileting at 4 am. Toilet before brunch, after brunch and after support and after outings. Offer toileting at 11pm, NOCS [over night shift] to check on rounds and toilet as needed. I would like to wear incontinent protection for dignity purposes. Ensure my urinal is within reach." R22's Bladder Assessment dated 5/19/2020, identified R22's Treatment Program as "scheduled toileting/habit training. During an interview on 8/16/21, at 5:06 p.m. R22 sat in his wheelchair in his room. R22 had poor voice quality, spoke in soft tone and did not annunciate words, R22 was difficult to understand. R22 would answer question yes or no with "thumbs up" for yes, "thumbs down" for no.	2 910		

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2 910	Continued From page 9 During an observation on 8/17/21, at 11:55 a.m. R22 was wheeled back to his room by unidentified staff member. At 11:59 a.m. nursing assistant (NA)-D and NA-E entered R22's room and hooked him up to the full body mechanical lift. NA's transferred R22 from his chair to his bed. Once R22 was in bed, NA's assisted R22 to roll back and forth to check his incontinent garment; NA-D stated R22 was dry. NA's then positioned R22 in bed, washed their hands and exited R22's room without asking and/or attempting to toilet R22. During an observation on 8/17/21, at 2:53 p.m. NA-F and NA-G entered R22's room. NA-G informed R22 she was going to check R22's incontinent brief. NA stated R22 was pretty wet. NA's then performed incontinent care for R22. Neither NA's asked R22 if he wanted to go to the toilet/use bedpan/and/or urinal. NA-G stated they did not offer to take R22 to the bathroom because he had Parkinson's disease, he was a full body mechanical lift, and it hurt him to sit on the toilet. When R22 was asked what his preference was for toileting, R22 pointed to the bathroom, stated did not prefer bed pan, and when asked if it hurt to sit on the toilet, R22 put his thumb down indicating "no". During an interview on 8/19/21, at 9:40 p.m. director of nursing (DON) stated she expected staff to follow care plans for individualized toileting programs. Facility Urinary Incontinence-Clinical Protocol dated 4/2018 included: The staff will identify environmental interventions and assistive devices that facilitate toileting. As appropriate, based on assessment of the category and	2 910		

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2 910	Continued From page 10 causes of incontinence, the staff will provide scheduled toileting, prompted voiding, or other interventions to try to improve the individuals continence status. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' dependant on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure their personal toileting needs are met in accordance the comprehensive assessment in conjuction with resident preferences for toileting. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections;	21390		9/24/21

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21390	Continued From page 11 F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to perform hand hygiene when performing wound care treatments to reduce the risk and/or prevent infections for 2 of 4 residents (R22 and R38) whose treatments were observed for pressure ulcer and surgical wound care. Findings include: R22's face sheet dated 8/19/21, included diagnoses of diabetes type 2, pressure ulcer of left buttock stage 2, and pressure ulcer of right buttock stage 3. R22's annual Minimum Data Set (MDS) assessment, dated 4/4/21, indicated R22 had intact cognition and had one stage 3 pressure ulcer that required pressure ulcer care. R22's physician orders included: -Wound for Sacral area: change dressing daily and as needed. 1) remove old dressing. 2) cleanse wound with normal saline and warm	21390	REVIEWED/CORRECTED	

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21390	Continued From page 12 soapy water. 3) Apply Prisma or sheet collagen to wound base and calmoseptine to periwound and redness 4) Cover with mepliex border or equivalent dressing (order start date 8/6/21) -Wound care orders for maintaining healthy buttock/sacrum skin 1) inspect and clean buttock gently with warm wet wash cloth 2) place a small amount of barrier cream on the buttocks and irritated skin to prevent maceration and breakdown/wounds. 3. Cover with foam padding at bedtime (order start date 8/2/21) During an observation on 8/18/21, at 12:12 p.m. R22 laid in his bed. Registered nurse (RN)-A entered R22's room and informed R22 she was going to change his dressing on his bottom, R22 consented. R22 was assisted to roll onto his left side by nursing assistant (NA)-D. RN-A washed hands and put gloves on, she then moved the garbage can to the side of the bed. RN-A then took off the gloves and put on new gloves without performing hand hygiene. RN then removed the sacral dressing and cleansed the area. RN-A removed the gloves and put on new gloves without performing hand hygiene and completed the treatment per physician order. RN-A indicated since there was not a dressing to the wound on the left buttock, RN-A had to go get one, RN-A washed her hands then left the room. RN-A returned to R22's room washed her hands and applied gloves. RN-A then cleansed the wound, applied the cream to the wound base with one of her gloved fingers, removed the glove, applied a new glove to right hand, and applied the dressing. RN-A then washed her hands. During an interview on 8/18/21, at 12:28 p.m. RN-A stated she should have performed hand hygiene between glove changes.	21390		

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21390	Continued From page 13 R38 surgical wound R38's face sheet dated 8/19/21, included diagnoses of acute appendicitis with perforation R38's admission Minimum Data Set (MDS) dated 6/4/21, indicated R38 had intact cognition and had a surgical wound that required surgical wound care. R38's physician orders included Abdomen incision: cleanse with soap and water, apply dry to dry gauze to midline wound two times a day for wound healing (order start date (8/13/21) During an observation on 8/18/21, at 8:09 a.m. R38 laid in bed, licensed practical nurse (LPN)-B entered the room and informed R38 it was time to change her dressing, R38 consented. LPN-B washed his hands then picked up the garbage can and moved it to bed side. Without performing hand hygiene LPN-B put gloves on and removed the gauze cover dressing and the gauze that was packed inside the wound. LPN-B then removed the gloves and without performing hand hygiene, donned new gloves, cleansed the wound, then applied the treatment per physician order. During an interview on 8/18/21, at 8:25 a.m. LPN-B stated he should have had gloves on when moving the garbage can and indicated an unawareness of appropriate hand hygiene between glove changes. During an interview on 8/19/21,a t 9:35 a.m. director of nursing (DON) stated nurse should have performed hand hygiene after touching the garbage can and should have performed hand hygiene after taking gloves off and before putting	21390		

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21390	Continued From page 14 on new gloves. Facility Policy Dressing Change Procedure dated 5/14/2019, included the following: Position resident Wash and dry your hands thoroughly. Put on clean gloves Loosen tape and remove soiled dressing Pull glove over dressing and discard into plastic or biohazard bag. Wash and dry your hands thoroughly Open dressing packages Wash and dry hands thoroughly Put on clean gloves Cleanse the wound with ordered cleanser. Apply the ordered dressing Remove disposable gloves and wash and dry your hands thoroughly. Facility policy Handwashing/Hand Hygiene dated 8/2015 included the following: Use an alcohol based hand rub or soap and water for following situations: before handling clean or soiled dressings, gauze pads, etc. before moving from a contaminated body site to a clean body site during resident care, after contact with blood or bodily fluids, after handling used dressings, contaminated equipment. after removing gloves. SUGGESTED METHOD OF CORRECTION: The ICP or designee could review facility policies/procedures regarding appropriate infection control technique during dressing changes. The ICP or designee could provide staff education regarding the policies and educate staff on appropriate IC technique while performing dressing changes. The ICP or designee should complete timely audits to ensure policies are being followed to ensure on-going	21390		

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21390	Continued From page 15 competence. The ICP, or designee should take education verifications and the audits to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for continued monitoring. TIME PERIOD FOR CORRECTION: 21 (twenty-one) DAYS	21390		
21525	MN Rule 4658.1305 A.B.C Pharmacist Service Consultation A nursing home must employ or obtain the services of a pharmacist currently licensed by the Board of Pharmacy who: A. provides consultation on all aspects of the provision of pharmacy services in the nursing home; B. establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and C. determines that drug records are accurately maintained and that an account of all controlled drugs is maintained. This MN Requirement is not met as evidenced by: On 8/18/21, at 2:25 p.m. a tour of the medication room containing the E-Kit medication storage cabinet was conducted with licensed practical nurse (LPN)-A. The E-Kit was found to contain controlled substances that are used for pain and anxiety. LPN-A indicated the facility staff do not verify the kit is secured or verify the 4 green tags securing the E-kit are verified. LPN-A indicated if they use a medication from the kit they fill out a sheet of paper included in the kit and send it to the pharmacy who then sends the medication to	21525	REVIEWED/CORRECTED	9/24/21

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21525	Continued From page 16 the director of nursing (DON) who replaces it. LPN-A further indicated if they open the kit, there are new green tags present inside to re-secured the kit. In addition, the refrigerator, unlocked and in the medication room included injectable Ativan (a controlled medication used to treat anxiety) that was in a clear plastic case, secured with a numbered green tag sitting on the shelf. The LPN-A indicated they do not have a process to verify the medication is still secured or present. LPN-A indicated the pharmacy is responsible for that or the director of nursing when she replaces the medication that is used or taken out of the kit. Interview with the director of nursing (DON) on 8/18/21, at 2:45 p.m. confirmed the E-kits contained controlled substances and are not reconciled or monitored by facility staff. The DON indicated the pharmacy is responsible for that. On 8/19/21, at 8:30 a.m., the DON indicated she spoke to the pharmacist regarding the E-kits and the pharmacist indicated the facility is not responsible for the E-kits as they are the property of the pharmacy and not the facilities responsibility. Attempted to contact the pharmacist who was out of the office. Review of the facility's Controlled Substance policy effective 4/1/2019 included: - Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal and record keeping in the facility, in accordance with federal and state laws and regulations.	21525		

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21525	Continued From page 17 - The director of nursing and the consultant pharmacist in collaboration maintain the facility's compliance with federal and state laws and regulations in the handling of controlled medications. Only authorized licensed nursing and pharmacy personnel have access to controlled medications. - Accurate accountability of the inventory of all controlled drugs is maintained at all times. When a controlled substance is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR). - Date and time of administration (MAR, Accountability Record). - Amount administered (Accountability Record) - Remaining quantity (Accountability Record) - Initials of the nurse administering the dose, completed after the medication is actually administered (MAR, Accountability Record). SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and the Consulting Pharmacist could establish a system to reconciliation and ensure there is a policy to instruct nurses on documentation and adhering to the reconciliation policy. The DON could randomly audit the system and report audits to the quality assurance committee. TIME PERIOD OF CORRECTION: Fourteen (14) days.	21525		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen	21535		9/24/21

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	00750	A. BUILDING: _____ B. WING _____	C 08/19/2021

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21535	Continued From page 18 must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview, and document review the facility failed to offer and/or attempt non-pharmacological interventions prior to the administration of as needed (PRN) opioid pain medications for 2 of 5 (R47 and R66) reviewed for unnecessary medications. Findings include R47's face sheet dated 8/19/21, included diagnoses of chronic pain syndrome, abnormal results of liver studies, major depressive disorder, end stage renal failure, and generalized	21535	REVIEWED/CORRECTED	

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21535	Continued From page 19 epilepsy. R47's annual Minimum Data Set (MDS) assessment dated 7/18/21, indicated R47 did not have cognitive impairment and for activities of daily living required extensive assistance from one staff member. The MDS identified R47 had pain, received scheduled and PRN pain medications, and utilized non-medication interventions for pain. The MDS also identified R47 was administered opioid pain medications. R47's physician orders for pain medications included: -Oxycodone (opioid pain medication) 5 mg (milligrams) one time a day for moderate pain (pain rated 4-7 out of 10); severe pain (rated 8-10) and every 4 hours as needed for chronic pain/non acute pain (start date 12/29/20) -Acetaminophen-codeine 300/30 mg (opioid pain medication) give two tablets five times a day related to chronic pain syndrome (start date 12/29/21) -Fentanyl patch (opioid pain patch) 100 mcg/hr (micrograms/hour) apply patch transdermally [to skin] one time a day every three days for chronic pain syndrome (start date 5/26/21) R47's Pain assessment dated 7/29/21, indicated R47 was able to report presence, location, and characteristics of pain. The assessment indicated R47 had mild pain daily that increased with movement and transfers; pain was relieved with rest, relaxation, and as needed pain medications. The assessment identified R47's individualized non-pharmacological interventions for relieving pain were: relaxation, massage, and distraction. R47's pain care plan dated 7/12/18, indicated	21535		

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21535	Continued From page 20 R47 may experience pain or discomfort related to history of left femur fracture, recurrent right septic hip and debility related to chronic pain. Associated pain interventions included, "help me try some non-drug pain relief techniques: neutral body alignment and positioning, linens smooth and comfortable, reminiscing and relation techniques. Provide instruction/demonstration as necessary (date 3/5/2015)". Other interventions included: evaluate the nature of pain and administer pain medication as ordered and determine if working. R47's August medication administration record (MAR) was reviewed in conjunction with progress notes; R47's record lacked location or characteristics of pain and lacked evidence of non-pharmacological interventions prior to administration of PRN pain medication. The following are examples: -R47's MAR on 8/12/21, at 7:57 p.m. oxycodone 5 mg was administered for pain rated 8/10. Corresponding progress note indicated oxycodone was administered with no other information pertaining to R47's pain. -R47's MAR on 8/15/21, at 11:40 a.m. oxycodone 5 mg was administered for pain rated 9/10. Corresponding progress note indicated oxycodone was administered with no other information pertaining to R47's pain. -R47's MAR on 8/16/21, at 11:40 a.m. oxycodone 5 mg was administered for pain rated 9/10. Corresponding progress note indicated oxycodone was administered with no additional information about R47's pain. -R47's MAR on 8/18/21, at 12:40 a.m. oxycodone 5 mg was administered for pain rated 10/10. Corresponding progress note included, "requested to [sic] pain all over"; no other	21535		

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21535	Continued From page 21 information pertaining to pain and/or interventions was included. -R47's MAR on 8/18/21, at 1:06 p.m. oxycodone 5 mg was administered for pain rated 9/10. Corresponding progress note indicated oxycodone was administered with no additional information pertaining to R47's pain. During an interview on 8/18/21, at 7:13 a.m. licensed practical nurse (LPN)-B reviewed R47's record and confirmed documentation of location of pain was not identified; LPN-B stated R47 reports her pain is all over. LPN-B stated an unawareness if R47's pain was related to muscle or joint pain. LPN-B indicated the record also did not identify if non-pharmacological interventions were attempted or offered. LPN-B indicated R47 typically was not willing to attempt non-pharmacological interventions and only wanted her pain pill, however stated the refusals should be documented. During an interview on 8/19/21, at 9:18 a.m. director of nursing (DON) reviewed R47's record, DON verified inconsistent documentation of pain location and non-pharmacological interventions attempted/offered. DON stated ideally there would be documentation of pain location and non-pharmacological interventions used or attempted. R66's face sheet indicated diagnoses of other chronic pain, pain in right shoulder and low back pain. R66's quarterly MDS dated 8/7/2021 indicated R66 required one person physical assist with dressing, bathing and transfers and had a functional limitation in range of motion on one side of upper extremity.	21535		

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21535	Continued From page 22 R66's physician order for medication included the following: -Oxycodone (narcotic pain medication) 5 mg Give 0.5 tablet every 6 hours as needed for chronic pain. -Acetaminophen 500 mg Give 2 tablets every 6 hours as needed for mild to moderate pain. -Diclofenac Sodium Gel 1% (pain relief cream) Apply to areas of pain topically four times a day for mild to moderate pain -Gabapentin 100 mg Give 1 capsule two times a day for pain. -Lidocaine patch 5% Apply to shoulder topically two times a day for shoulder pain. R66's pain evaluation dated 8/10/2021 indicated R66 experiences mild pain less than daily that increased with right upper extremity movement and increased activity; pain was relieved with medication, rest and compression. The evaluation further indicated non-pharmacological interventions included physical and occupational therapy and right upper extremity compression. R66's care plan indicated to assist R66 to try some non-drug pain relief techniques such as neutral body alignment and positioning, linens smooth and comfortable, reminiscing and relaxation techniques. R66's August medication administration record (MAR) and progress notes were reviewed and showed R66's record lacked characteristics of pain, location of pain and further lacked evidence of non-pharmacological interventions utilized prior to administration of as needed (PRN) pain medication. The following are examples: -R66's MAR on 8/13/21, at 7:40 P.M., oxycodone	21535		

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21535	Continued From page 23 2.5 mg was administered for pain rated 8/10. Corresponding progress note indicated oxycodone was administered with a follow up pain scale of 5/10 with no other information pertaining to R66's pain. -R66's MAR on 8/14/21, at 2:11 A.M., oxycodone 2.5 mg was administered for pain rated 5/10. Corresponding progress note indicated oxycodone was administered with no follow up pain scale and no other information pertaining to R66's pain. -R66's MAR on 8/14/21, at 9:57 P.M., oxycodone 2.5 mg was administered for pain rated 6/10. Corresponding progress note indicated oxycodone was administered with no follow up pain scale and no other information pertaining to R66's pain. -R66's MAR on 8/15/21, at 9:19 P.M., oxycodone 2.5 mg was administered for pain rated 6/10. Corresponding progress note indicated oxycodone was administered with no follow up pain scale and no other information pertaining to R66's pain. -R66's MAR on 8/17/21, at 9:42 P.M., oxycodone 2.5 mg was administered for pain rated 6/10. Corresponding progress note indicated oxycodone was administered with no follow up pain scale and no other information pertaining to R66's pain. During an interview on 8/18/21, at 12:16 P.M., LPN-A stated staff try to suggest non-pharmacological interventions such as massage, heat, ice or elevation but R66 often refuses. LPN-A also stated staff are to document in a progress note what interventions were offered and if R66 refused. Facility policy Administration procedures for all	21535		

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21535	Continued From page 24 medications dated 4/1/2019, included: When administering an "as needed" (PRN) medication document reason for giving, observe medication actions/reactions and record on the PRN effectiveness sheet/nurse's notes. Facility Pain Policy dated 6/2/14 included, When pain is identified in a resident staff will identify the location and severity of pain. Staff will document effectiveness of non-pharmacological and pharmacological interventions. Staff will notify physician of resident's pain when: when pain is not effectively treated with non-pharmacological interventions and pharmacological interventions. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring and documentation of pain and utilization of non-pharmacological interentions prior to the administration of opioid pain medications. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIMEFRAME FOR CORRECTION: Twenty-one (21) days.	21535		
21550	MN Rule 4658.1325 Subp. 1 Adminiatration of Medications; Pharmacy Serv. Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This MN Requirement is not met as evidenced	21550		9/24/21

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21550	Continued From page 25 by: Based on interview and document review the facility failed to ensure physician ordered medication was available for administration in accordance with physician orders for 1 of 3 residents (R6) reviewed for medication administration. In addition, the facility failed to ensure a system for periodic reconciliation of controlled substance medications in 2 of 2 emergency kits (E-Kit) to prevent potential loss or diversion. Furthermore, a controlled substance located in the refrigerator was not double locked. This had the potential to affect the residents present in the facility, who may require controlled medications from the E-Kits. Findings include R6's face sheet dated 8/19/21, indicated R6 had diagnosis of chronic pain. R6's annual Minimum Data Set (MDS) assessment dated 5/23/21, indicated R6 did not have cognitive impairment. The MDS identified R6 was administered ointments/medications to places other than to feet and frequently had pain. R6's physician orders included: Aspercreme with lidocaine cream 4%, apply to both legs topically two times a day for pain. Apply from toes up to and including thighs AND apply to both legs topically as needed for pain an additional two times a day (start date 10/2/2020) R6's medication administration record (MAR) identified the morning doses of Aspercreme on 8/10 and 8/11/21, were not administered. Corresponding progress note dated 8/10/21 at 2:45 p.m. identified the medication was not	21550	REVIEWED/CORRECTED	

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21550	Continued From page 26 administered because the cream was "Not available." The progress note dated 8/11/21 at 1:20 p.m. identified the cream was not administered because "no cream available". During an interview on 8/17/21, at 8:45 a.m. R6 stated she could not remember if she had always gotten her pain creams applied per the doctors order. Facility pharmacy was called on 8/18/21, at 2:24 p.m. Pharmacy representative (PR)-A stated the pharmacy had received the refill request for R6's Aspercreme on 8/7/21 and delivered to the facility the afternoon of 8/11/21. PR stated 8/7/21, was a Saturday and the facility did not identify that the medication was needed urgently or emergently, therefore the medication was not immediately filled. PR stated because the resident did run out of the medication the pharmacy started sending three bottles at a time instead of only one. During an interview on 8/18/21, at 2:40 p.m. director of nursing (DON) confirmed R6 had run out of the Aspercreme medication; facility had ordered the medication however, had not received it from pharmacy until 8/11/21. DON indicated she had arranged for more bottles to be delivered at a time because of the amount R6 required daily. DON indicated the dose that was charted in the evening on 8/10/21, was documented in error. DON indicated she would have expected staff to follow-up with the pharmacy if the medication was not available for administration at schedule times and the provider be notified. SUGGESTED METHOD OF CORRECTION:	21550		

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21550	Continued From page 27 The director of nursing (DON) or designee could review and revise policies and procedures for pharmacy services, and how medication is ordered, transcribed, delivered and dispensed by the pharmacy. The director of nursing or designee could develop a system to educate staff about pharmacy services and the disposition of the medication. The quality assurance committee could monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21550		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that,	21880		9/24/21

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21880	Continued From page 28 at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a written transfer notice was given to 4 of 5 residents (R7, R66, R22, and R38) upon transfer to the hospital. In addition, the facility failed to have a system in place to ensure residents were given written notices upon transfer. This deficient practice had the potential to affect all 69 residents residing in the facility. Findings include R22 R22's quarterly Minimum Data Set (MDS) assessment indicated R22 did not have cognitive impairment. R22's progress note dated 7/30/21, at 7:52 p.m.	21880	REVIEWED/CORRECTED	

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21880	Continued From page 29 indicated R22 was transferred to the hospital after staff had discovered severe redness to both upper thighs and hips. R22's progress note dated 8/2/21, at 1:51 p.m. indicated R22 had returned to the facility. R38 R38's admission MDS assessment dated 6/4/21, indicated R38 did not have cognitive impairment. R38's progress note dated 7/5/21, indicated R38 was transferred at 2:00 a.m. to the hospital via ambulance following a fall. R38's progress note dated 7/8/21, indicated R38 had returned to the facility at 10:45 a.m. R7 R7 was transferred to the hospital via ambulance on 7/31/2021, at 6:40 a.m., after R7 fell. R7 returned to the facility on 7/31/21, at 2:15 p.m. R7 was transferred to the hospital via ambulance on 6/22/2021, at 8:58 a.m. for dislodged nephrostomy tube (thin catheter inserted into the kidney to drain urine) and returned to the facility at 4:45 p.m. R7 was transferred to the hospital via ambulance on 4/13/2021, at 1:30 p.m., for blood in urine and was readmitted to the facility on 4/23/2021, at 1:20 p.m. R7 was transferred to the hospital via ambulance on 5/7/2021, at 11:19 a.m. with increased confusion and shortness of breath and returned to the facility on 5/10/2021, at 1:20 p.m. Upon request to review written transfer notice on 8/17/21, at 2:43 p.m., the director of nursing	21880		

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21880	Continued From page 30 (DON) indicated they did not put anything in writing to the resident or their family. The DON indicated a transfer form went with the resident to the hospital and bed holds were completed by social services but wasn't aware of any written transfer form and questioned if this was a new regulation. During interview on 8/18/21, at 9:04 a.m., the business office manager (BOM), social services manager and DON indicated they were not providing a written statement to the resident and/or their family at time of discharge. The BOM indicated she started her role last September. R66 R66's Admission MDS assessment dated 5/13/2021 indicated R66 had no cognitive impairment. R66 was transferred to the emergency department on 7/1/2021 for cough and shortness of breath and returned the same day. R66 was transferred to the emergency department on 7/25/2021 and hospitalized for Acute and Chronic Respiratory Failure. R66 returned to the facility on 7/31/2021. During an interview on 8/19/2021 at 8:45 A.M., R66 stated the facility verbally explained why R66 was being sent to the emergency department but did not provide paperwork that stated the reason behind being transferred to the emergency department. During an interview on 8/19/2021, RN-A stated the facility does not provide a transfer document to the resident explaining why the resident is	21880		

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	00750	A. BUILDING: _____ B. WING _____	C 08/19/2021

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

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21880	Continued From page 31 being transferred, they tell the resident and their representative verbally. Undated facility policy Bed Hold and Return to Facility Policy and Procedure included; indicated that resident and resident representative would be provided with notification of transfer discharge, reason for move, in writing in a language and manner they can understand, Readmission or return to the facility policy, admission standards. Suggested Method of Correction: The Director of Nursing or designee could review policies and procedures, train staff, and implement measures regarding the facility's policy regarding notifications of transfers of residents. The director of nursing or designee, could conduct random audits of transferred residents, to ensure appropriate documentation is provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21880		
21925	MN St. Statute 144.651 Subd. 29 Patients & Residents of HC Fac.Bill of Rights Subd. 29. Transfers and discharges. Residents shall not be arbitrarily transferred or discharged. Residents must be notified, in writing, of the proposed discharge or transfer and its justification no later than 30 days before discharge from the facility and seven days before transfer to another room within the facility. This notice shall include the resident's right to contest the proposed action, with the address and telephone number of the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12). The resident, informed of this right, may choose to relocate before the	21925		9/24/21

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21925	Continued From page 32 notice period ends. The notice period may be shortened in situations outside the facility's control, such as a determination by utilization review, the accommodation of newly-admitted residents, a change in the resident's medical or treatment program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a reasonable effort to accommodate new residents without disrupting room assignments. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow their grievance process for missing personal property for 1 of 1 residents (R63) who reported missing property. Findings include: R63's Quarterly Minimum Data Set (MDS) assessment dated 8/1/21, identified R63 had impaired cognition. During an interview on 8/16/21, at 3:20 p.m., R63 indicated staff had lost his bottom teeth and "haven't done a damn thing to fix the problem." R63 further indicated no one had offered to replace them or send him to a dentist to get a new bottom set of dentures. R63 estimated it had been at least 3 months since he last had them and he told staff they were missing. R63 states he is having difficulty with chewing his food and has had weight loss. During observation on 8/17/21, at 8:39 a.m., a	21925	REVIEWED/CORRECTED	

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21925	Continued From page 33 nursing assistant approached R63 and asked if he would like his teeth in and R63 did not respond. During interview on 8/17/21, at 9:35 a.m., R63 stated staff lost his bottom denture months ago and haven't done a thing to solve the problem. During interview on 8/17/21, at 9:27 a.m., nursing assistant (NA)-A indicated she wasn't sure if R63 had both upper and lower dentures, but thought only uppers. NA-A indicated she would verify with the nurse and the electronic medical record (EMR) and let me know. During interview on 8/17/21 at 9:43 a.m., NA-A stated R63's bottom dentures are missing currently and a missing belongs form was completed and turned into social services (SS) just now. During interview on 8/17/21, at 11:52 a.m., R63 indicated two girls came into his room this morning and searched all over for his lower denture plate. R63 stated he has told them before but they kept telling him his teeth were in his mouth. R63 stated he told them over and over and until this morning no one believed him. During interview on 8/17/21, at 1:12 p.m., NA-B indicated she noticed when R63 was moved down to this wing that his bottom denture plate was missing. NA-B indicated she was on another unit where he was before it closed for remodeling and had informed the nurse. During interview on 8/17/21 at 1:13 p.m., NA-C indicated R63 had not mentioned his missing lower denture plate since the first week he	21925		

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21925	Continued From page 34 moved to this unit a few months ago at least. During interview on 8/17/21, at 1:20 p.m., SS-A indicated she just received a missing belongings sheet this morning for R63's missing bottom denture plate. SS-A indicated staff were searching for them now and if they aren't found she will notify the family. A "Missing Item" form dated 8/17/21 indicated R63 is missing bottom denture and signed by NA-B. A policy titled "Grievance Policy" dated 10/16 included: - It is the policy of this facility that each resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. - The facility will ensure prompt resolution to all grievances, keeping the resident and the resident representative informed throughout the investigation and resolution process. - A grievance or concern can be expressed orally to the grievance official or facility staff or in writing using a grievance form which will be located in main dining room, outside Director of Social Services Office. - Any employee of this facility who receives a complaint shall immediately attempt to resolve the complaint within their role and authority. If a complaint cannot be immediately resolved the employee shall escalate that complaint to their supervisor and the facility grievance official. SUGGESTED METHOD OF CORRECTION: The licensed social workers or designee could	21925		

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21925	Continued From page 35 develop and implement policies and procedures to ensure that residents receive the required followup for missing personal items; educate all staff. Then develop monitoring systems to ensure ongoing compliance and report the findings to the quality coittee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21925		