

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MX1X

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00336

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245416	3. NAME AND ADDRESS OF FACILITY (L3) MINNESOTA VALLEY HEALTH CENTER INC (L4) 621 SOUTH 4TH STREET (L5) LE SUEUR, MN (L6) 56058	4. TYPE OF ACTION: <u>2</u> (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint
2.STATE VENDOR OR MEDICAID NO. (L2) 804242000	5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (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
6. DATE OF SURVEY 08/02/2021 (L34)	8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other	FISCAL YEAR ENDING DATE: (L35) 09/30
11. LTC PERIOD OF CERTIFICATION From (a) : To (b) :	10.THE FACILITY IS CERTIFIED AS: X A. In Compliance With Program Requirements Compliance Based On: <u>1</u> . Acceptable POC B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: A* (L12)	And/Or Approved Waivers Of The Following Requirements: <u>2</u> . Technical Personnel <u>6</u> . Scope of Services Limit <u>3</u> . 24 Hour RN <u>7</u> . Medical Director <u>4</u> . 7-Day RN (Rural SNF) <u>8</u> . Patient Room Size <u>5</u> . Life Safety Code <u>9</u> . Beds/Room
12.Total Facility Beds 50 (L18)	13.Total Certified Beds 50 (L17)	14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF ICF IID 50 (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 Elizabeth Silkey, Unit Supervisor (L19)	Date : 10/19/2021	18. STATE SURVEY AGENCY APPROVAL Melissa Poepping, Enforcement Specialist (L20)	Date: 10/19/2021
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PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY <u>X</u> 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) <u>VOLUNTARY</u> <u>00</u> <u>INVOLUNTARY</u> 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement 03-Risk of Involuntary Termination <u>OTHER</u> 04-Other Reason for Withdrawal 07-Provider Status Change 00-Active
28. TERMINATION DATE:	29. INTERMEDIARY/CARRIER NO. 00131 (L28) (L31)	30. REMARKS
31. RO RECEIPT OF CMS-1539 (L32)	32. DETERMINATION OF APPROVAL DATE 08/17/2021 (L33)	DETERMINATION APPROVAL



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 19, 2021

CMS Certification Number (CCN): 245416

Administrator
Minnesota Valley Health Center Inc
621 South 4th Street
Le Sueur, MN 56058

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 9, 2021 the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 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,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 19, 2021

Administrator
Minnesota Valley Health Center Inc
621 South 4th Street
Le Sueur, MN 56058

RE: CCN: 245416
Cycle Start Date: June 30, 2021

Dear Administrator:

On August 12, 2021, we notified you a remedy was imposed. On October 13, 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 9, 2021.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective September 30, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of July 22, 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 September 30, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on September 9, 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,

A handwritten signature in black ink, appearing to read 'Melissa Poepping'.

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MX1X

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00336

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245416		3. NAME AND ADDRESS OF FACILITY (L3) MINNESOTA VALLEY HEALTH CENTER INC (L4) 621 SOUTH 4TH STREET (L5) LE SUEUR, MN (L6) 56058		4. TYPE OF ACTION: <u>2</u> (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint	
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11. LTC PERIOD OF CERTIFICATION From (a) : To (b) :		10.THE FACILITY IS CERTIFIED AS: A. In Compliance With <u> </u> And/Or Approved Waivers Of The Following Requirements: Program Requirements <u> </u> 2. Technical Personnel <u> </u> 6. Scope of Services Limit Compliance Based On: <u> </u> 3. 24 Hour RN <u> </u> 7. Medical Director <u> </u> 1. Acceptable POC <u> </u> 4. 7-Day RN (Rural SNF) <u> </u> 8. Patient Room Size <u> </u> 5. Life Safety Code <u> </u> 9. Beds/Room X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B* (L12)			
12.Total Facility Beds 55 (L18)		13.Total Certified Beds 55 (L17)		14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF ICF IID 55 (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 Craig Rosfjord, HFE NE II		Date : 08/09/2021 (L19)		18. STATE SURVEY AGENCY APPROVAL Melissa Poepping, Enforcement Specialist		Date: 08/13/2021 (L20)	
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PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY <u> </u> 1. Facility is Eligible to Participate <u> </u> 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 : <u> </u>	
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31. RO RECEIPT OF CMS-1539 (L32)		32. DETERMINATION OF APPROVAL DATE (L33)		DETERMINATION APPROVAL	



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 22, 2021

Administrator
Minnesota Valley Health Center Inc
621 South 4th Street
Le Sueur, MN 56058

RE: CCN: 245416
Cycle Start Date: June 30, 2021

Dear Administrator:

On June 30, 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by September 30, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 30, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

Minnesota Valley Health Center Inc

July 22, 2021

Page 4

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,



Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

PRINTED: 07/30/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245416		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/30/2021	
NAME OF PROVIDER OR SUPPLIER MINNESOTA VALLEY HEALTH CENTER INC				STREET ADDRESS, CITY, STATE, ZIP CODE 621 SOUTH 4TH STREET LE SUEUR, MN 56058			
(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			E 000			
	On 06/28/21 to 06/30/21, 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.						
F 000	INITIAL COMMENTS On 06/28/21 to 06/30/21, a standard recertification survey was conducted at your facility. A complaint investigation was 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: H5416020C (MN71322), however NO deficiencies were cited due to actions implemented by the facility prior to survey: The following complaints were found to be UNSUBSTANTIATED: H5416016C (MN53612), H5416017C (MN55708), H5416018C (MN66071), and H5416019C (MN67969). 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			F 000			

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

TITLE

(X6) DATE

Electronically Signed

07/30/2021

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.

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

PRINTED: 07/30/2021
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245416	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/30/2021
NAME OF PROVIDER OR SUPPLIER MINNESOTA VALLEY HEALTH CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 621 SOUTH 4TH STREET LE SUEUR, MN 56058		
(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 be used as verification of compliance.	F 000			
F 761 SS=D	Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained. Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure doses of controlled substances	F 761			7/30/21
			Tag F761 06/29/2021: Work order request to		

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

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NAME OF PROVIDER OR SUPPLIER MINNESOTA VALLEY HEALTH CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 621 SOUTH 4TH STREET LE SUEUR, MN 56058		
(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 761	Continued From page 2 were stored in a manner to reduce the risk of theft and/or diversion in 1 of 2 refrigerators observed in use for medication storage. This had potential to affect 1 of 1 residents who received this medication. Findings include: During observation and interview on 6/28/21, at 4:54 p.m. in the Meadow nurses station, licensed practical nurse (LPN)-A opened the locked medication refrigerator. This refrigerator was a two compartment mini-fridge with separate freezer and refrigerator compartments. The refrigerator compartment had a lock on the outside. LPN-A unlocked and opened the refrigerator. Inside was a small, clear acrylic box measuring approximately 4 inches by 8 inches, which was also locked. LPN-A removed the box from the refrigerator and unlocked it. Inside was a bottle of Ketamine 100 mg oral liquid, 19 milliliters, prescribed for R1. The acrylic box was not affixed to the inside of the refrigerator in order to prevent theft. During a telephone interview on 6/29/21, 10:21 a.m. consultant pharmacist (CP)-B stated Ketamine was a schedule III medication and it needed to be locked up. Informed the medication was in a locked refrigerator, in a locked acrylic box, but the acrylic box was not permanently affixed to the refrigerator per regulation. CP-B stated he thought it was...he never jiggled it. Facility policy titled Controlled Medication Storage policy indicated schedule III-V medications and other medications subject to abuse may be stored in a permanently affixed compartment separate from all other medications.	F 761	permanently affix the acrylic medication box to the inside of medication refrigerator completed. The refrigerator locks and the acrylic box inside the refrigerator is locked and permanently attached to the refrigerator. This was noted in the survey in the citation on June 29, 2021. All other medication refrigerators were checked and verified to be in compliance. For the next 30 days the refrigerators will be checked weekly by the Administrator monthly by the Maintenance department for six months. Annual inspection process updated to include verification of functionality and security of medication refrigerators/boxes to support sustained compliance.		

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

PRINTED: 07/30/2021
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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 761	Continued From page 3 During an interview on 6/29/21, at 10:43 a.m. registered nurse (RN)-A stated she was not aware Ketamine was a scheduled III medication and should be in a permanently affixed compartment in the refrigerator. RN-A stated she will speak to maintenance to get the box affixed to the inside of the refrigerator. During an interview on 6/29/21, at 11:00 a.m. the administrator and director of nursing were informed of Ketamine, a scheduled III medication being utilized by R1. Neither were aware of a resident using this medication, nor that it should be stored in a permanently affixed compartment. The DON stated she could see why that would be important to prevent theft. Administrator stated she would ask maintenance to do this right away. During an observation on 6/29/21, at 1:04 p.m. licensed practical nurse (LPN)-B opened the refrigerator on Meadow nurses station. The acrylic box with Ketamine inside was permanently affixed to the inside of the refrigerator. Facility policy titled Controlled Medication Storage, dated 5/26/21, indicated: --Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage...in accordance with federal, state and other applicable laws and regulations. --Schedule III-V medications and other medications subject to abuse may be stored in a permanently affixed compartment separate from all other medications.	F 761			

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

PRINTED: 08/11/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245416		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/30/2021	
NAME OF PROVIDER OR SUPPLIER MINNESOTA VALLEY HEALTH CENTER INC				STREET ADDRESS, CITY, STATE, ZIP CODE 621 SOUTH 4TH STREET LE SUEUR, MN 56058			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 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 06/30/2021. At the time of this survey, Ridgeview LeSueur Medical Center (Minnesota Valley Memorial NC) 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

08/01/2021

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. Ridgeview LeSueur Medical Center (Minnesota Valley Memorial NC) is a 1-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1967 and was determined to be of Type II(111) construction. In 1996, an addition was constructed to the East Wing that was determined to be of Type II(111) construction. Because the original building and addition meet	K 000			

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K 000	Continued From page 2 the construction type allowed for existing buildings, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and resident rooms, that is monitored for automatic fire department notification. The facility has a capacity of 55 beds and had a census of 20 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000			
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.	K 324			9/30/21

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K 324	Continued From page 3 Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper safety and security related to a cooking device in a resident accessible corridor in accordance with the Life Safety Code NFPA 101, 2012 edition, section 19.3.2.5.3. This deficient condition could have a isolated impact on the residents within the facility. Findings Include: On 06/30/2021 between 09:30 AM and 01:30 PM, it was revealed during the walk-through of the facility that in the Physical Therapy / Occupational Therapy Room, the stove was found to be in an active and functioning state, having no lock-out capabilities This deficient practice was confirmed by the Facility Administrator at the time of discovery.	K 324	K324 1. An approved master lock out system will be installed to the therapy range to ensure safe operation. 2. Facilities will perform an inspection of the system monthly. 3. Facilities will ensure this work is inspected monthly by using the building management program. 4. Ridgeview Facilities is responsible. 5. Findings will be corrected by September 30, 20221		
K 353 SS=E	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	K 353			9/30/21

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K 353	Continued From page 4 with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect and maintain the sprinkler system in accordance with the Life Safety Code NFPA 101, 2012 edition, sections 9.7.5, 9.7.6, and NFPA 25, 2011 edition, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.2.2. This deficient condition could have an patterned impact on the residents within the facility. Findings Include: On 06/30/2021 between 09:30 AM and 01:30 PM, it was revealed during the walk-through of the facility that: 1. In the Dining Room Storage closet, items were stacked to high and could affect the proper operation of the sprinkler head 2. In the basement Medical Records Storage,	K 353	K353 1. In the Dining Room Storage closet, items have been removed and nothing is stacked within 18 inches of the ceiling. 2. Dietary Manager and staff have been re-educated on Life Safety regulations. 3. Situation will be monitored monthly. 4. Inspection will be added to the monthly checklist using the Building Management Program. 5. In the basement Medical Records Storage, all cabling that was resting on the sprinkler system has been re-hung. 6. Cabling Contractor has been re-educated. 7. Compliance will be assured through monitoring through the monthly safety check. 8. Monthly check will be added to the Building management Program.		

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K 353	Continued From page 5 cabling was found to be resting on the sprinkler system piping as-well-as obstructing a fire sprinkler head	K 353			
K 355 SS=D	This deficient practice was confirmed by the Facility Administrator at the time of discovery. 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: Based on observation and staff interview, the facility failed to maintain proper installation height of portable fire extinguishers in accordance with the Life Safety Code NFPA 101 - 2012 edition, sections 19.3.5.12, 9.7.4.1, and NFPA 10 Standard for Portable Fire Extinguishers, 2010 edition, section 6.1.3.8. This deficient condition could have an isolated impact on the residents within the facility. Findings Include: On 06/30/2021 between 09:30 AM and 01:30 PM, it was revealed during the walk-through of the facility that in the Community Room that a fire extinguisher was mounted higher than five feet This deficient practice was confirmed by the Facility Administrator at the time of discovery.	K 355	K355 1. The fire extinguisher in the community has been lowered to the correct height per the regulations. 2. Central Fire Protection will perform an annual fire extinguisher inspection to ensure compliance. 3. Facilities will monitor this annual PM through our internal building management program. 4. Ridgeview Facilities is responsible.		9/30/21
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101	K 372			9/30/21

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K 372	Continued From page 6 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper subdivision of building space in the form of smoke barrier construction in accordance with the Life Safety Code NFPA 101 - 2012 edition, sections 19.3.7.7, 8.5.1, and 8.5.2. This deficient condition could have a widespread impact on the residents within the facility Findings Include: On 06/30/2021 between 09:30 AM and 01:30 PM, it was revealed during the walk-through of the facility, that it could not be confirmed that proper smoke barrier protection was in place, above ceiling, at the smoke barrier doors of Meadow Corridor. This deficient practice was confirmed by the Facility Administrator at the time of discovery.	K 372	K372 1. The smoke barrier in the Meadow will be corrected with appropriate materials by ISG. 2. Facilities will perform an annual assessment of fire barriers with ISG to ensure they are compliant. 3. Facilities will be the owner of this task. 4. Ridgeview Facilities is responsible.		
K 761 SS=F	Maintenance, Inspection & Testing - Doors	K 761			9/30/21

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K 761	Continued From page 7 CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on document review, and staff interview, the facility failed to provide confirming documentation associated to maintenance, inspection and testing of doors in accordance with the Life Safety Code NFPA 101 - 2012, sections 19.7.3.1, 19.7.6, 4.6.12, and the Standard for Fire Doors and Other Opening Protectives NFPA 80-2010, section 5.2.1. This deficient condition could have a widespread impact on the residents within the facility. Findings Include: On 06/30/2021 between 09:30 AM and 01:30 PM, it was revealed during documentation review that door inspection and testing records were incomplete as only five points of assessment were completed for each door. This deficient practice was confirmed by the	K 761	K761 1. We have adopted the correct form to use from the MN State Fire Marshal's office and it will be implemented in the 2021 inspections. 2. Facilities will perform the annual fire inspection to ensure compliance. 3. Facilities will monitor this annual inspection through our internal building management process. 4. Ridgeview Facilities is responsible.		

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K 761	Continued From page 8			K 761			
K 914	Maintenance Director at the time of discovery.			K 914			
SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101						9/30/21
	Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to properly document the annual electrical receptacle testing in accordance with the Health Care Facilities Code NFPA 99 - 2012 edition, sections 6.3.3.2, 6.3.4.1 and 6.3.4.2. This deficient condition could have a widespread impact on the residents within the facility. Findings Include:				K914 1. We have adopted the correct form to use from the MN State Fire Marshals office and it will be implemented in the 2021 inspections. 2. Facilities will perform the annual inspections to ensure compliance. 3. Facilities will perform this annual inspection through our internal building managements process.		

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K 914	Continued From page 9 On 06/30/2021 between 09:30 AM and 01:30 PM, it was revealed during documentation review that the records provided for review were generic in content, not providing detailed information associated to the individual outlets located in resident rooms.	K 914	4. Ridgeview Facilities is responsible.		
K 920 SS=E	This deficient practice was confirmed by the Maintenance Director at the time of discovery. Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by:	K 920		9/30/21	

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K 920	Continued From page 10 Based on observation and staff interview, the facility failed to properly manage the implementation and usage of power strips in accordance with Health Care Facilities Code NFPA 99, section 10.2.3.6, 10.2.4 and the National Electrical Code NFPA 70, 2011 edition, sections 400-8, 590.3(D). This deficient condition could have a patterned impact on the residents within the facility. Findings Include: 1. On 06/30/2021 between 09:30 AM and 01:30 PM, it was revealed during the walk-through of the facility that in the Community Relations Specialist Office - power-strips were in use and daisy-chained together. 2. On 06/30/2021 between 09:30 AM and 01:30 PM, it was revealed during the walk-through of the facility that in the Financial Assistant Office - power-strips were in use and daisy-chained together. 3. On 06/30/2021 between 09:30 AM and 01:30 PM, it was revealed during the walk-through of the facility that in the Community Room - power-strips were in use and daisy-chained together. This deficient practice was confirmed by the Maintenance Director at the time of discovery.	K 920	K920 1. The electrical power strips found out of compliance have been removed. 2. Facilities will perform an annual assessment of office spaces to ensure the proper applications are being used. 3. Facilities will monitor this annual PM through our web based work order system IWMS. 4. Ridgeview Facilities is responsible.		
K 923 SS=D	Gas Equipment - Cylinder and Container Storage CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet	K 923			9/30/21

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K 923	Continued From page 11 Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain operational ventilation of the medical gas containment storage room in	K 923	K923 1. The O2 room ventilation systems have been corrected.		

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

PRINTED: 08/11/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245416	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/30/2021
NAME OF PROVIDER OR SUPPLIER MINNESOTA VALLEY HEALTH CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 621 SOUTH 4TH STREET LE SUEUR, MN 56058		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 923	Continued From page 12 accordance with the Health Care Facilities Code NFPA 99, 2012 edition, sections 9.3.7.4, 9.3.7.5, 9.3.7.5.3, 11.5.2.3.2 and the Compressed Gases and Cryogenic Fluids Code NFPA 55, 2010 edition, sections 6.4.2, 6.15, 6.15.1. This deficient condition could have a isolated impact on the residents within the facility. Findings Include: On 06/30/2021 between 09:30 AM and 01:30 PM, it was revealed during the walk-through of the facility it could not be confirmed that the exhaust fan was functioning or operational. This deficient practice was confirmed by the Maintenance Director at the time of discovery.	K 923	2. Facilities performs annual ACH testing to all critical spaces. 3. Facilities will monitor this annual PM through our internal building management program. 4. Ridgeview Facilities is responsible.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 22, 2021

Administrator
Minnesota Valley Health Center Inc
621 South 4th Street
Le Sueur, MN 56058

Re: Event ID: MX1X11

Dear Administrator:

The above facility survey was completed on June 30, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Joanne Simon', with a horizontal line extending to the right.

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00336	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/30/2021
NAME OF PROVIDER OR SUPPLIER MINNESOTA VALLEY HEALTH CENTER INC		STREET ADDRESS, CITY, STATE, ZIP CODE 621 SOUTH 4TH STREET LE SUEUR, MN 56058		
(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) COMPLETE DATE
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 06/28/21 to 06/30/21, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure and no correction orders are issued.	2 000		

Minnesota Department of Health

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

TITLE

(X6) DATE

Electronically Signed

07/30/21

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00336	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/30/2021
NAME OF PROVIDER OR SUPPLIER MINNESOTA VALLEY HEALTH CENTER INC		STREET ADDRESS, CITY, STATE, ZIP CODE 621 SOUTH 4TH STREET LE SUEUR, MN 56058		
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2 000	Continued From page 1 Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE 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	2 000		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00336	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/30/2021
NAME OF PROVIDER OR SUPPLIER MINNESOTA VALLEY HEALTH CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 621 SOUTH 4TH STREET LE SUEUR, MN 56058		
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2 000	Continued From page 2 MINNESOTA STATE STATUTES/RULES.	2 000			