CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

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PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY	

ID:	NJ39
Faci	lity ID: 00668

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Tammy Williams, HFE -	NE II	1	1/29/2017	(L19)	Joanne S	Simon, Enforcm	nent Specialist	: 11/29/2017 (L20)
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00668

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

On September 18, 2017 through September 20, 2017 a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR 483, Subpart B, and requirements for Long Term Care Facilities.

On September 21, 2017 and September 22, 2017 an extended survey was completed at this facility. The most serious deficiency (F323) was cited at a S/S level of J. Conditions in the facility at the time of the survey constituted both Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) to resident health and safety. The IJ began on June 12, 2017. The Administrator and DON were notified of the IJ on September 21, 2017 at 11:09 a.m. The IJ was abated on September 22, 2017 at 3:39 p.m., however non-compliance remained at a lower S/S level of G. Post Certification Revisit to follow.

Refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction.



Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245564

November 29, 2017

Ms. Autumn Roark, Administrator Browns Valley Health Center 114 Jefferson Street South Browns Valley, MN 56219

Dear Ms. Roark:

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

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

Effective October 27, 2017 the above facility is recommended for:

41 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 41 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered November 29, 2017

Ms. Autumn Roark, Administrator Browns Valley Health Center 114 Jefferson Street South Browns Valley, MN 56219

RE: Project Number S5564027

Dear Ms. Roark:

On October 4, 2017, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective October 9, 2017. (42 CFR 488.422)

Also on October 4, 2017, we recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

• Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for an extended survey completed on September 22, 2017. The most serious deficiency was found to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

On November 14, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on October 27, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on September 22, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 27, 2017. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on September 22, 2017, as of October 27, 2017.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective October 27, 2017.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedy outlined in our letter of October 4, 2017.

• Civil money penalty for deficiency sited at F323, be imposed. (42 CFR 488.430 through 488.444)

Browns Valley Health Center November 27, 2017 Page 2

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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

Feel free to contact me if you have questions.

Sincerely,

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 29, 2017

Ms. Autumn Roark, Administrator Browns Valley Health Center 114 Jefferson Street South Browns Valley, MN 56219

Re: Reinspection Results - Project Number S5564027

Dear Ms. Roark:

On November 14, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 22, 2017, with orders received by you on October 4, 2017. At this time these correction orders were found corrected.

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

Please feel free to call me with any questions.

Sincerely,

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

MEDICARE/MEDICAID	CERTIFICATIO	N AND TKAN	SWIII IAL
PART I - TO RE COMPLE	TED BY THE ST	TATE SHEVE	VACENCY

Facility ID: 00668

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00668

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

On September 18, 2017 through September 20, 2017 a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR 483, Subpart B, and requirements for Long Term Care Facilities.

On September 21, 2017 and September 22, 2017 an extended survey was completed at this facility. The most serious deficiency (F323) was cited at a S/S level of J. Conditions in the facility at the time of the survey constituted both Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) to resident health and safety. The IJ began on June 12, 2017. The Administrator and DON were notified of the IJ on September 21, 2017 at 11:09 a.m. The IJ was abated on September 22, 2017 at 3:39 p.m., however non-compliance remained at a lower S/S level of G. Post Certification Revisit to follow.

Refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction.



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered October 4, 2017

Ms. Autumn Roark, Administrator Browns Valley Health Center 114 Jefferson Street South Browns Valley, MN 56219

RE: Project Number S5564027

Dear Ms. Roark:

On September 22, 2017, an extended survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

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

<u>Removal of Immediate Jeopardy</u> - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

<u>No Opportunity to Correct</u> - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

<u>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 6 months after the survey date; and

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

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

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on September 22, 2017, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us

Phone: (218) 332-5140 Fax: (218) 332-5196

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

• State Monitoring effective October 9, 2017. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

• Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Browns Valley Health Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective September 22, 2017. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care, which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services Departmental Appeals Board, MS 6132 Civil Remedies Division Attention: Karen R. Robinson, Director 330 Independence Avenue, SW Cohen Building, Room G-644 Washington, DC 20201

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated

in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

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

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 remedy be imposed:

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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 December 22, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 22, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions related to this letter.

Sincerely,



Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us

Phone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

PRINTED: 10/24/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245564	B. WING			09/	22/2017
NAME OF PROVIDER OR SUPPLIER BROWNS VALLEY HEALTH CENTER				1	STREET ADDRESS, CITY, STATE, ZIP CODE 114 JEFFERSON STREET SOUTH BROWNS VALLEY, MN 56219		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	FC	000			
F 225 SS=D	Department of Hea 21 and 22, 2017. To and 22, 2017. To appropriate interver practice resulted in or death. The IJ beyond on Septer As a result of identicare, an extended so september 21 and as your allegation of Department's acception of the form. Your electron be used as verificate Upon receipt of an on-site revisit of you validate that substate regulations has been your verification. 483.12(a)(3)(4)(c)(1)(4)(1)(1)(3) Not employ or owho-	f correction (POC) will serve of compliance upon the otance. Because you are our signature is not required a first page of the CMS-2567 nic submission of the POC will cion of compliance. acceptable electronic POC, andur facility may be conducted to intial compliance with the en attained in accordance with a compliance with I)-(4) INVESTIGATE/REPORT DIVIDUALS	F 2	225			10/27/17
I ABORATOR'	.,	DER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE		TITLE		(X6) DATE

Electronically Signed 10/11/2017

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

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F 225	(ii) Have had a findinurse aide registry exploitation, mistreamisappropriation of (iii) Have a disciplinor her professional body as a result of exploitation, mistreamisappropriation of (4) Report to the St licensing authorities actions by a court of which would indicat nurse aide or other (c) In response to a exploitation, or mist (1) Ensure that all a abuse, neglect, expincluding injuries of misappropriation of reported immediate after the allegation cause the allegation cause the allegation serious bodily injury the events that cause and do not retain the administrator of officials (including tradult protective serior jurisdiction in lor	propriation of property, or court of law; Ing entered into the State concerning abuse, neglect, atment of residents or their property; or ary action in effect against his license by a state licensure a finding of abuse, neglect, atment of residents or resident property. Attenurse aide registry or any knowledge it has of flaw against an employee, e unfitness for service as a	F 2:	25		

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F 225	thoroughly investigated (3) Prevent further pexploitation, or mist investigation is in percentage (4) Report the result administrator or his representative and with State law, incluated Agency, within 5 woif the alleged violatic corrective action may active action may assed on interview facility failed to report and potential neglet for 1 of 3 (R29) resulting abuse/neglect/neglet injury of unknown swithin 24 hours, and aware of a fracture R29 also sustained where fall interventificality failed to report within 2 hours where addition, the facility completion of a thour resident (R29) revisioning with serious the resident (R29) revisioning linclude:	chat all alleged violations are ated. cotential abuse, neglect, creatment while the rogress. Its of all investigations to the or her designated to other officials in accordance ading to the State Survey orking days of the incident, and on is verified appropriate ast be taken. It is not met as evidenced and document review, the ort injuries of unknown source at of care to the State agency adents reviewed for ect of care. R29 sustained an ource that was not reported at then when staff became failed to report within 2 hours. In a fractured hip following a fall ons were not in place, and the ort potential neglect of care in aware of the fracture. In failed to implement policy for rough investigation for 1 of 1 aware with a injury of unknown	F 2.	F225 Browns Valley Health Center injuries of unknown origin and neglect of care to the State A The facility completed a thoro investigation of R29 injury of origin dated 6/12/17 on 10/10 All residents have the potenti impacted by a deficient pract area. The facility's Maltreatment Poguidelines were reviewed and 9/30/17. All Charge Nurse stre-educated on the process of any injuries to Administrator, on-call RN. All designated Streporters will be re-educated center's Malpractice Policy at reporting guidelines. Educatid done via the Nurse's meeting be held on 10/25/17.	d potential gency. bugh unknown 0/17. fall to be ice in this blicy reporting d revised on taff will be porting DON, or tate Agency on the care and the icon will be	

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F 225	chronic obstructive recurrent major dependent of the control of th	with behavioral disturbance, pulmonary disease and pression. simum Data Set (MDS) dated 29 had diagnoses which osteoporosis and depression. 9 had severe cognitive quired extensive assistance ene, toileting, transfers and r, the MDS identified R29 had	F 2	25	All incidents will be audited by DON/designee to ensure a thoroug investigation is completed to identificand the care plan is updated with nointerventions. Audits will be done of the for 2 weeks, then 2x week for 2 weeks then weekly. Staff will be re-educed an ongoing basis as needed based results of the audits. The auditing will be reported monthly to the Performance Review team on 10/1 and quarterly to the full QAPI team 11/14/17. The QAPI team will mak recommendations for ongoing more Completion date for F225 is Oct. 2017	ew lx week eks, ted on l on the results 9/17 on e iitoring.	

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F 225	knee was also note with movement of the R29 reported, "I fel after the fall. The refor all transfers with portable x-ray was indicated a portable fracture of her distaincluded written stawhich noted R29 happroximately 6:30 visible bruises and time. The staff stat rounds had been changed was sleeping at the pain. A staff written indicated the staff is morning cares on a findicated during called arm hurt and staff and front of her right included written staindicated R29's below position a weel personnel had bee Maintenance had been heeded to be to the lowest position until the nestatement from ma 6/13/17, indicated I approximately 3 indicated in position possible, of the bed and installed meeting note dated been noted to have pain in her right should be to the lowest position to the lowest position possible, of the bed and installed meeting note dated been noted to have pain in her right should be the lowest position to the lowest position possible to the lowest position possib	age 4 ed. R29 winced with discomfort the area. The report indicated I" and denied any assistance eport listed staff were to use 2 in a gait belt until after the completed. The report ex-ray done identified a all right clavicle. The record attements from staff dated ad been assisted to bed at inp.m. on 6/11/17, and had no no complaints of pain at that ement indicated 5:00 a.m. completed on 6/12/17, and she at time and no complaints of a statement dated 6/13/17, member had assisted R29 with 6/12/17. The statement res, R29 had indicated her found bruises on her shoulder in the grown and maintenance in notified of the broken bed. Betermined new parts for the ordered, and adjusted the bed on, and would remain in that ew part installed. The written intenance personnel dated he had set the bed in ches higher than the lowest ordered the needed parts for eat the parts on 6/13/17. An IDT is 6/13/17, indicated R29 had a bruising and complaints of oulder during morning cares. staff had asked R29 what had stated she fell and	F 2	225		

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F 225	was revised to inclutate time. No docur investigation of the noted, no further are or function of the sbeen completed. Review of R29's profollowing: -6/12/17, at 8:15 as squeezed right shoof pain. R29 had a clavicle region, swe site. A scrape was knee. R29 stated asked if anyone hero. R29's primary orders were received Two staff assistance transfer belt until Profole 12/17, at 7:59 p. fracture of distal rigphysician was notificated region of 6/13/17, incident recares NAR (nursing indicated R29 com shoulder area and the top of the right R29 stated she fell	I her get up. R29's care plan ude 2 assist for transfers at mentation of further cause of R29's injury was nalysis of the effectiveness/use afety devices in place had ogress notes revealed the mentation of the model and complained a bruise on top of her right elling was noted around the noted also below R 29's right she fell when asked, and when liped her she shook her head physician was notified and led for a PPX (portable x-ray). See for R29 with all transfers and PX completed. In results of x-ray indicated the clavicle. R29's primary ied. I her get up. R29's care plan at mentation of the first plan and the shoot plan and the shoot plan and plan an	F 2	225			

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F 225	up. An x-ray complifracture of the distart at the time of incided Review of R29's Incomplete Investigation Report following: -8/20/17, at 12:45 at found R29 on the flowalker in her room. indicated she was good buff the floor." The been observed earl off herself. R29 de The report indicated out of resident sight take off the alarm of 8/21/17, R29 indicated out of resident sight take off the alarm of 8/21/17, R29 indicated fracture of the left floor degrees varus angular fragment. An IDT midentified staff noted TABS alarm earlier delusional and was The note indicated was to reapply the she could not remoindicated on 8/21/11 leg and hip pain, gutransfer. Further, the been transferred to left hip fracture. The plan had been followed.	was hard to get herself back eted at 7:59 p.m. revealed a I right clavicle. The care plan	F 2	225		

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	other interventions R29's fall on 8/20/1 Review of R29's profollowing: -8/20/17, at 12:45 a coming from R29's outside of her roomher room. R29 stated oor and buff the flucentimeter bump or discomfort. Ice was back to bed with as belt. R29 was obsettime. Informed she and R29 continued Alarm moved out of -8/21/17, at 8:30 a. pain when she was was guarding her lephysician was notificatived. -8/21/17, at 10:00 proforesident on bed resident on bed resident on bed resident on bed resident on services and servic	noval/unhook of alarms, no had been implemented prior to 7. ogress notes revealed the a.m. staff heard a noise room. She was on the floor and her walker was inside ted she was going to shut the por. R29 sustained a 2 and her head and denied a applied. R29 was assisted sistance of 2 staff and gait erved to unhook alarm at this a needed to keep the alarm on to play with alarm buttons.	F 2	25		
	report had been sul a.m. Review of R29's inv	on to OHFC identified the omitted on 8/22/17, at 8:55 vestigation summary of the vealed on 8/20/17, at 12:45				

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F 225	proximity of R29's outside her room of the staff she was go she could buff the firshift to be restless behaviors. R29 derinext day she compound was completed at Ship fracture. The cast was followed. During interview or the administrator at the administrator at the administrator at the administrator at the administrator of policy and stated the report to SA. She strequirement for 2 hand confirmed the that time requirement stated the usual proximmediately, no lat stated she was not report cases of ser knowledge. She confrom 8/20/17, was been reported with injury. At 1:45 p.m. had reviewed R29's members involved, R29 could tell them meet the requirement reported in 2 hours. On 9/20/17, at 3:04 registered nurse (Finurse (LPN)-A, RN cognitive impairment)	noise coming from the room. Staff observed her in the floor. R29 indicated to oing to close the door so that floor. Was noted earlier in the and had some delusional nied pain at that time. The lained of pain, and an x-ray 0:30 p.m. and revealed a left are plan at the time of incident in 9/20/17, at 12:56 p.m. with and director of nursing (DON), confirmed the current facility in facility had 24 hours to stated she was aware of the flour reporting for serious injury facility's current policy reflected ent. At 12:58 p.m. the DON actice was to report er than 24 hours to SA. She aware of the requirement to ious injury within 2 hours of infirmed the findings for R29 a serious injury, and it had not in 2 hours of knowledge of the the administrator stated she is fall on 6/12/17, with the staff and the staff had felt because in she fell, the incident did not ents for unknown injury to be in the confirmed R29 had severe in the severe R29 had severe R29 had severe	F 22			

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F 225 F 226 SS=D	R29's clavicle fractions she felt R29 was rignot and felt her cog RN-A indicated she communicate effect. On 9/21/17, at 7:16 talked with R29 after bruises on her shout told her she "fell", and one assisted her up. She indicated shourising on R29 was the facility policy to Services of Morris Signature Maltreatment Report any suspected maltinjuries of unknown later than 2 hours if 483.12(b)(1)-(3), 48 DEVELOP/IMPLME POLICIES 483.12 (b) The facility mus written policies and (1) Prohibit and pre exploitation of resident property,	lated to the incident when are was found. RN-A indicated ght on and sometimes she was nitive status was intermittent. If left R29 could still tively. a.m. RN-A confirmed she had er she was noted to have alder and indicated R29 had and had not asked for help and or and it was hard for her to get the felt the cause of the strom the reported fall. Itiled, St Francis Health Skilled Nursing Facility ring Guidelines, 11/18/16, included each care to the state agency (OHFC) treatment, which included a source immediately, but not it result in serious bodily injury. It is serious between the intermittent in the injury between the injury. It is serious between the injury between the inj	F2			10/27/17	

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F 226	\$483.95, 483.95 (c) Abuse, neglect, the freedom from a requirements in § 4 provide training to the educates staff on- (c)(1) Activities that exploitation, and many property as set forth (c)(2) Procedures for neglect, exploitation resident property (c)(3) Dementia many prevention. This REQUIREMED by: Based on interview facility failed to impleated adult reporting policy reporting, not later agency (SA) for 2 for abuse/neglect/man injury of unknown reported within 24 from the place, and the facility neglect of care with fracture. In addition implement policy for investigation for 1 control of the place in the place in the facility failed to implement policy for investigation for 1 control of the place in the place in the facility fracture. In addition implement policy for investigation for 1 control of the place in the pla	as required at paragraph and exploitation. In addition to buse, neglect, and exploitation 83.12, facilities must also heir staff that at a minimum constitute abuse, neglect, isappropriation of resident	F 22	F226 Browns Valley Health Center will the facility s Maltreatment Policy Procedure on VA reporting. All residents have the potential to impacted by a deficient practice i area. The facility s Maltreatment Policy reporting guidelines were reviewed revised on 9/30/17. All Charge Notaff will be re-educated on the upolicy reporting guidelines were reviewed revised on 9/30/17. All Charge Notaff will be re-educated on the care center of Maltreatment Policy reporting guidelines were reviewed to the care center of Maltreatment Policy reporting guidelines were reviewed to the care center of Maltreatment Policy reporting guidelines were reviewed to the care center of Maltreatment Policy reporting guidelines were reviewed to the care center of Maltreatment Policy reporting guidelines were reviewed to the care center of Maltreatment Policy reporting guidelines were reviewed to the care center of Maltreatment Policy reporting guidelines were reviewed to the care center of Maltreatment Policy reporting guidelines were reviewed to the care center of Maltreatment Policy reporting guidelines were reviewed to the care center of Maltreatment Policy reporting guidelines were reviewed to the care center of Maltreatment Policy reporting guidelines were reviewed to the care center of Maltreatment Policy reporting guidelines were reviewed to the care center of Maltreatment Policy reporting guidelines were reviewed to the care center of Maltreatment Policy reporting guidelines were reviewed to the care center of Maltreatment Policy reporting guidelines were reviewed to the care center of Maltreatment Policy reporting guidelines were reviewed to the care center of Maltreatment Policy reporting guidelines were reviewed to the care center of the care center o	y and be n this y ed and lurse pdated delines. s elines	

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F 226	injury. Findings Include: The facility policy to Services of Morris Maltreatment Reported to the reviewed/amended center must reported any suspected malinjuries of unknown later than 2 hours if the Review of R29's signed 9/5/17, identified dementian chronic obstructive recurrent major department, and rewith dressing, hygical locomotion. Further a fall since the priorical R29's significant chidentified R29 had required extensive hygiene, eating and with transfers, toile. R29's current care 3:04 p.m. last update registered nurse (Potential for abuse.	itled, St Francis Health Skilled Nursing Facility rting Guidelines, 11/18/16, included each care to the state agency (OHFC) treatment, which included a source immediately, but not if result in serious bodily injury. Igned Physician Order Sheet, tified diagnoses which with behavioral disturbance, pulmonary disease and bression. Imum Data Set (MDS) dated 29 had diagnoses which osteoporosis and depression. 9 had severe cognitive quired extensive assistance ene, toileting, transfers and r, the MDS identified R29 had	F 226	All incidents will be monitored by the Administrator to ensure timely reportine State Agency is done. Audits done 4x week for 2 weeks, then 2 for 2 weeks, then weekly. Nursing progress notes will be monitored eday to ensure that the appropriate Agency reporting staff been notific incidents to determine need for account and timely VA reporting. Staff will re-educated on an ongoing basis an needed based on the results of the The monitoring results will be reported to the Performance Reviet on 10/19/17 and quarterly to the future on 11/14/17. The QAPI tear make recommendations for ongoin monitoring. Completion date for F226 is Oct. 2 2017	orting to will be x week gevery State ed of any ccurate be as e audits. orted ew team ull QAPI m will ng	

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F 226	cognitive deficits ar activities of daily livifurther indicated R2 needed assistance and instructed staff Review of R29's Inc Investigation Report following: -6/12/17, at 8:00 a. Indisorientated, and other right shoulder with top of her right claviswelling around the knee was also note with movement of the R29 reported, "I fell after the fall. The refor all transfers with portable x-ray was indicated a portable fracture of her distaincluded written stawhich noted R29 has approximately 6:30 visible bruises and time. The staff state rounds had been cowas sleeping at that pain. A staff written indicated the staff morning cares on 6 indicated during car arm hurt and staff for and front of her righincluded written staindicated R29's bed	ge 12 Ind required assistance with ing (ADL)s. The care plant indicated in a care	F 2	26			

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F 226	Maintenance had d bed needed to be of to the lowest position position until the nestatement from main 6/13/17, indicated in approximately 3 incomposition possible, of the bed and installed meeting note dated been noted to have pain in her right shour that time. No document in the note indicated happened and she nobody had helped was revised to inclust that time. No document investigation of the noted, no further arror function of the sabeen completed. Review of R29's profollowing: -6/12/17, at 8:15 as squeezed right shour of pain. R29 had a clavicle region, swe site. A scrape was knee. R29 stated sasked if anyone helmo. R29's primary porders were received Two staff assistance transfer belt until Plantage in the noted in t	n notified of the broken bed. etermined new parts for the redered, and adjusted the bed on, and would remain in that w part installed. The written ntenance personnel dated be had set the bed in hes higher than the lowest redered the needed parts for d the parts on 6/13/17. An IDT 6/13/17, indicated R29 had bruising and complaints of oulder during morning cares. Staff had asked R29 what had stated she fell and her get up. R29's care plan and 2 assist for transfers at nentation of further cause of R29's injury was allysis of the effectiveness/use after devices in place had obgress notes revealed the m. R29 grabbed and alder winced and complained bruise on top of her right lling was noted around the noted also below R 29's right he fell when asked, and when ped her she shook her head onlysician was notified and and for a PPX (portable x-ray). The for R29 with all transfers and	F 2:	26		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		245564	B. WING			09/	22/2017
	PROVIDER OR SUPPLIER S VALLEY HEALTH C	ENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 114 JEFFERSON STREET SOUTH BROWNS VALLEY, MN 56219	,	
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F 226	fracture of distal rig physician was notificated on 6/13/17. Incident recares NAR (nursing indicated R29 compshoulder area and the top of the right R29 stated she fell, she did not ask for assisted her, and it up. An x-ray compfracture of the distal at the time of incider R29's Inc	ht clavicle. R29's primary ed. on to Office of Health Facility) identified the report had been 17, at 1:07 p.m. vestigation summary of the vealed on 6/12/17, during a.m. g assistant registered) staff blained of pain in her right noted a bruise and swelling at clavicle region. When asked, and then went on to say that help and that nobody had was hard to get herself back leted at 7:59 p.m. revealed a I right clavicle. The care plan	F 2	226			
	found R29 on the fl walker in her room. indicated she was of "buff the floor." The been observed earl off herself. R29 de The report indicated out of resident sigh take off the alarm of 8/21/17, R29 indicated left leg and hip area was unwilling to trathat time, identified	a.m. staff heard a noise and our outside her room, with her R29 was disorientated and going to close the door and report identified R29 had ier in the shift taking alarms nied discomfort at that time. It is staff were to place bed alarm that and reach, so she would not refer turn the alarm off. On ted she had discomfort in her a, guarding of the area and insfer. A x-ray completed at an acute intertrochanteric emur associated with 90					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION			E SURVEY PLETED
		245564	B. WING			09/2	22/2017
	PROVIDER OR SUPPLIER S VALLEY HEALTH C	ENTER		STREET ADDRESS, CITY, STATE, ZIP OF 114 JEFFERSON STREET SOUTH BROWNS VALLEY, MN 56219	CODE		
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F 226	degrees varus anguar fragment. An IDT midentified staff noted TABS alarm earlier delusional and was The note indicated was to reapply the she could not remoindicated on 8/21/1 leg and hip pain, guaransfer. Further, the been transferred to left hip fracture. The plan had been follow R29's fall was docu R29's repeated remother interventions R29's fall on 8/20/1 Review of R29's profollowing: -8/20/17, at 12:45 a coming from R29's outside of her room her room. R29 stated door and buff the flocentimeter bump of discomfort. Ice was back to bed with as belt. R29 was obsettime. Informed she and R29 continued Alarm moved out of -8/21/17, at 8:30 a. I pain when she was was guarding her leg	ulation of the femoral shaft neeting note dated 8/22/17, d that R28 had removed her in the shift and was talking unsettled earlier in the shift. The immediate intervention TABS alarm and place where we it herself. The note 7, R29 had complained of left narded leg and was unwilling to e note indicated R29 had the hospital for evaluation of a enote indicated R29's care wed. No further analysis of mented. However, despite noval/unhook of alarms, no had been implemented prior to 7. Ogress notes revealed the a.m. staff heard a noise room. She was on the floor and her walker was inside ed she was going to shut the foor. R29 sustained a 2 on her head and denied applied. R29 was assisted sistance of 2 staff and gait erved to unhook alarm at this needed to keep the alarm on to play with alarm buttons.	F 2	26			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTIO A. BUILDING A. BUILDING				E SURVEY IPLETED		
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F 226	fracture of left hip. notified. Orders for resident on bed res midnight and to trar morning. Review of submissi report had been sul a.m. Review of R29's inv. 8/20/17, incident re a.m. staff heard a reproximity of R29's routside her room of the staff she was go she could buff the f shift to be restless a behaviors. R29 den next day she completed at 9 hip fracture. The car was followed. During interview on the administrator are the administrator are the administrator are the administrator of policy and stated the requirement for 2 hand confirmed the fithat time requirement stated the usual praimmediately, no late stated she was not	a.m. x-ray results indicated R29's primary physician was foley catheter, to keep t, NPO (no oral intake) afternsfer for surgery in the on to OHFC identified the omitted on 8/22/17, at 8:55 restigation summary of the wealed on 8/20/17, at 12:45 oise coming from the oom. Staff observed her in the floor. R29 indicated to bing to close the door so that loor. Was noted earlier in the and had some delusional iied pain at that time. The ained of pain, and an x-ray:30 p.m. and revealed a left re plan at the time of incident 9/20/17, at 12:56 p.m. with and director of nursing (DON), onfirmed the current facility e facility had 24 hours to tated she was aware of the our reporting for serious injury acility's current policy reflected ent. At 12:58 p.m. the DON	F 2.	26		

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F 226	knowledge. She corfrom 8/20/17, was a been reported within injury. At 1:45 p.m. had reviewed R29's members involved, R29 could tell them meet the requirement reported in 2 hours.	a serious injury, and it had not a serious injury, and it had not a 2 hours of knowledge of the the administrator stated she a fall on 6/12/17, with the staff and the staff had felt because she fell, the incident did not ents for unknown injury to be	F 22	26		
	registered nurse (R nurse (LPN)-A, RN cognitive impairment hallucinations. She reliable historian rel R29's clavicle fractushe felt R29 was rig	indicated she felt R29 was a lated to the incident when ure was found. RN-A indicated the on and sometimes she was nitive status was intermittent. felt R29 could still				
F 241 SS=D	talked with R29 after bruises on her shout told her she "fell", a no one assisted her up. She indicated s bruising on R29 wa	a.m. RN-A confirmed she had er she was noted to have alder and indicated R29 had nd had not asked for help and r and it was hard for her to get he felt the cause of the s from the reported fall. TY AND RESPECT OF	F 2 ²	L1		10/27/17
	resident in a manne promotes maintena her quality of life red	et treat and care for each er and in an environment that nce or enhancement of his or cognizing each resident's cility must protect and of the resident.				

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F 241	by: Based on observatoreview the facility fadining experience of R29) who required the supper meal on Findings include: On 9/18/17, at 5:04 black and purple tilt reclining) wheelchather meal in front of seated in her whee meal in front of her empty chair and their space wheelchait angle. R5 had her reyes were closed at her mouth. Next to (NA)-I. NA-I was seelbow on the table of food, not talking with R4, R29 and Fable on her elbows offered spoonfuls of or engage R4 in coher to eat, and did during the meal. At 5:19 p.m., R29 of water. NA-I sat bac offering bites of food	ge 18 NT is not met as evidenced tion, interview and document ailed to ensure a dignified or 3 of 3 residents (R4, R5, assistance with eating during 19/18/17 in the dining room. p.m. R4 was seated in a tin space (adjustable ir positioned at the table with her. R29 was to the left of R4, Ichair at the table with her. To the left of R29 was an en R5 was seated in a black tilt r, reclined at a 45 degree meal in front of her, but her nd she was breathing through R5 was nursing assistant eated in a chair, leaning her as she fed R4 spoonfuls of the any of the residents. The mained seated at the table is she fed R4 spoonfuls of the any of the residents. The mained seated at the table is she fed R4. She did not talk, inversation while she assisted not talk or engage R29 or R5. The oughed, NA-I stood up and and offered her a glass of k down next to R4, resumed do to R4. NA-I did not talk to R4 her in conversation.	F 241	F241 Dignity Resident R4, R5, R29 will receive dignified care and treatment with rea a dignified dining experience. All residents have the potential to be treated in an undignified manner, experience impairments. Nursing staff will be re-educated or resident dignity, according to the fapolicy. Included in this education is mandatory in-servicing on "Feeding Dignity". Staff will be reminded to immediately report any potential correlated to resident dignity to their supervisor or any other member of care center management staff. Staeducation to take place on 10/19/1 10/20/17. Random observational audits will be on all residents during meal times in DON/designee a minimum of 4x will 2 weeks, then 2x week for 2 weeks monthly thereafter. Results of the monitoring will be reviewed during monthly Performance Review mee 10/19/17 and quarterly during the Competing on 11/14/17. The QI team make recommendations for ongoin monitoring. Completion date for F241 is Oct. 2 2017	pe esp. n acility s g with procerns aff 7 and pe done by the eek for s, then the ting on QAPI is will ag	

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F 241	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 24			

AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 241	the table with NA-I continue to carry or between themselver residents in conver At 6:02 p.m. R4 ar the dining room. On 9/18/17, at 7:45 been seated next to NA-F stated she fe themselves at mea continued in persor other throughout th On 9/21/17, at 2:46 assisted R4, R29 a 9/18/17. She conficonversation throug with NA-F and had conversation. She is was not a dignified NA-I confirmed, stat the past to limit per assisting residents On 9/21/2017, at (DON) confirmed s residents during me practice. She indicated on assist the past. Review of the undat Health Center Dignices ident shall be care.	29 and R5 remained seated at and NA-F. NA-F and NA-I in a personal conversation as, no attempts to engage the sation were observed. In R29 were assisted to leave as a sation were observed. In R29 were assisted to leave as a sation were observed. In R29 were assisted to leave as a sation were observed. In R29 were assisted to leave as a sation were observed. In R29 were assisted to leave as a sation were assisted to leave as a sation were as a sation were all to R5 during the supper meal. In R29 were assisted to leave as a sation were and R29 kept to leave and NA-I and conversation with each a supper meal and R5 with the supper meal and engaged the residents in andicated she was aware this experience for R4, R5 or R29. If had received reminders in a sonal conversations while with their meals. In R29 were assisted to leave as a sation were as a supper meal. In R29 kept to leave and NA-I and conversation with each engaged the residents in a supper meal on the supper meal on the supper meal and the supper meal and the supper meal and the supper meal and the supper meal on the	F 24	.1			

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE	
F 253 SS=D	(i)(2) Housekeeping necessary to maint comfortable interior This REQUIREMED by: Based on observatified to ensure a cowas maintained for observed to have of the served to have o	tion and interview the facility lean and sanitary environment 2 of 4 resident rooms verflowing garbage's. 2 a.m. a shared bathroom for R42, was observed to have a bwing with soiled incontinent of urine was also observed to bm. a.m. nursing assistant (NA)-E of NA's were not responsible for age's in resident rooms when a stated the facility was responsible for removing	F 2	F253 Browns Valley Health Cera clean and sanitary envir All residents having share have the potential to be in deficient practice in this a Facility Odor Elimination Freviewed and revised to informaintaining an odor from Nursing and Housekeepin re-educated on the procesoiled garbage in independent strooms/bathrooms by 10/25 Nurse to assign staff each garbage in independent strooms/bathrooms in orderodor. Larger garbage carscented bags, and an aut freshener to assist with or added to room 117/118 shaudit sheets will be placed 117/118 shared bathroom housekeeping to sign off to garbage is removed in orderodor from the bathroom en Random audits of the she completed by DON/Housed 4x week for 2 weeks, ther weeks, then monthly there be re-educated on an one	conment. and bathrooms inpacted by a rea. Policy was include a process are environment. and staff will be ass of removing adent resident and to eliminate and with a lid, and a	10/27/17	
		s, she would routinely find pared bathroom garbage		needed based on the results will			

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F 253	indicated in the pass her shared bathrood overflowing with so indicated she had exthe soiled products staff know if the gas before or after house R42's quarterly Min 9/16/17, identified FON 9/21/17, at 1:25 shared bathroom goverflowing with so stated she used to from the bathroom of the pile, however them up and was down assistant and activity weeks ago, about hoverflowing garbage R42 stated often time products would can which she could sm stated the evening remove the soiled in bathroom, and the following morning. On 9/21/17, at 1:31 director (ED) indicated the ever soiled in residents rooms, it responsible to remondant to the stated this would not s	iled incontinent products. H-A st R42 had reported to her that m garbage was routinely iled briefs. H-A further encouraged R42 to not pick up from the floor and to let facility rbage required changing	F 25	the monthly Performance F 10/19/17 and quarterly QA 11/14/17. The QAPI team recommendations for ongo Completion date for F253 i 2017	PI meeting on will make bing monitoring.		

	AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
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F 253	would empty reside only more if reques On 9/21/17, NA-K swas the evening shwould be to check to of the shift, prior to further indicated shand R42's shared because independent worked all shifts an garbage's on the scincluded R10 and FNA-C indicated he garbage's after he showever; residents cares would not ha and changed at the On 9/22/17, at 1:40 (DON) stated she wall residents rooms ensure the removal this would include Fbathroom. On 9/22/17, at 1:41 designee/activity di unaware R42 had ogarbage. On 9/22/17, at 2:30 coordinator indicate been told not to ent garbage's if the resfurther indicated the	ent garbage's once a day and ted by staff or residents. Stated her usual shift to work ift and her usual process residents garbage's at the end residents going to bed. NA-K e would often not check R10 pathrooms, as both residents with activities of daily living. 1 p.m. NA-C indicated he d he would not routinely check puth end of the building, which R42's rooms and bathroom. Would remove any soiled assisted residents with cares, who were independent with ve their garbage's checked	F 25	53		

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F 274 SS=D	from resident rooms cares, that included An undated facility policy, revealed it was upon receiving a costeps would be take policy did not addreresident environme 483.20(b)(2)(ii) COLAFTER SIGNIFICA (b)(2)(ii) Within 14 determines, or shouthere has been a siresident's physical opurpose of this sectimeans a major decresident's status that itself without further implementing standinterventions, that hone area of the resirequires interdisciplicare plan, or both.) This REQUIREMEN by: Based on interview failed to complete a Assessment (SCSA change in resident Minimum Data Set (R13) reviewed for Findings include:	s which were independent in I R10 and R42. coolicy titled, Odor Elimination was the policy of the facility implaint regarding orders, en to eliminate the odors. The ss maintaining an odor free int. MPREHENSIVE ASSESS	F 2		nanges vith ARD lized ed on change it did	10/27/17	

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F 274	and toileting. R13 h motion, did not requoccasionally incont occasional pain that no falls since the property of the property	o staff for transfers, dressing had no limitation in range of white oxygen and was inent of bowel. R13 also had at the was unable to rate and	F 274	,	ig. s will If be tifying d by the ve had icant d and A min of o	
	dressing, and toilet limitation in range of daily functions to a frequently incontine and had a surgical wound care. R13 in having moderate paracture other than Review of the above decline in cognition impaired, increase	m two staff for transfers, ing. R13 had a functional of motion that interfered with lower extremity. R13 was ent of bowel, required oxygen wound that required surgical adicated she was frequently ain and had a diagnosis of a a hip fracture. e assessments indicated a from intact to moderately in need for assistance with ing (ADL) for transfers,		needed based on the results of the The monitoring results will be reported monthly to the Performance Review on 10/19/17 and quarterly to the	rted w team API tions	

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	PROVIDER OR SUPPLIER S VALLEY HEALTH C	ENTER		STREET ADDRESS, CITY, STATE 114 JEFFERSON STREET SO BROWNS VALLEY, MN 56	E, ZIP CODE	
(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 ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 274	dressing and toiletir range of motion that to a lower extremity continence, increas increase in falls, ne of surgical wound completed dated 8/28/17, at 1:58 she had completed dated 8/28/17, as well dated 9/3/17. MDS discharge return an 8/17/17 was completed the Resident Assessmanual directed whoursing home after determine if criteria if the criteria are mecompleted. She also indicated the need to assessment when to were noted and not 14 days. MDS coorn hospitalization staff Monday morning the did not require a So stated there was a place decision in R13's many morning that the criteria is stated there was a place of progress a late entry for 8/21 director of nursing (facility as the previous "Reviewed on return ADL had not chang decrease as Fx [fra	ing, new functional limitation in the interfered with daily functions of a decline in bowel the infrequency of pain, who set of a fracture, initiation are and oxygen use. p.m. MDS coordinator stated R13's 5-day PPS assessment well as R13's quarterly MDS coordinator confirmed a ticipated (DCRA) MDS dated where the first of the infred sment Instrument (RAI) are a resident returned to the a DCRA MDS, the IDT must are met for a SCSA MDS and with a SCSA MDS must be confirmed and in a significant change who or more areas of change expected to be self-limiting to dinator stated after the met to discuss R13 at the erapy meeting and felt R13 CSA MDS. MDS coordinator progress note stating the	F 2	74		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245564	B. WING		09/	22/2017
_	PROVIDER OR SUPPLIER S VALLEY HEALTH C	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 114 JEFFERSON STREET SOUTH BROWNS VALLEY, MN 56219	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 274	Facility provided po Services of Morris I reviewed date of 4/ conduct a compreh standardized asses functional capacity, regulations, Rules a the Centers for Med State of Minnesota. The Resident Assedated 10/16, includ significant change a a resident's status to the constitute of the care 1. Will not normally intervention by staff disease-related clind'self-limiting' (for de 2. Impacts more that health status; and 3. Requires interdisting revision of the care The manual further determined that a set the nursing home is identification of the clinical record. The constitutes a signification that it is a sed upon the judiclarified that MDS as	licy titled, St. Francis Health MDS 3.0 Assessment, with a 6/15, indicated "Policy: To ensive, accurate and sment of each resident's using the RAI manual and and Status [sic] specified by dicare and Medicaid and the " ssment Instrument manual ed the definition of a as a decline or improvement in that: resolve itself without for by implementing standard ical interventions, is not clines only); an one area of the resident's ciplinary (IDT) review and/or	F 2	74		
F 278 SS=D	483.20(g)-(j) ASSE ACCURACY/COOF	SSMENT RDINATION/CERTIFIED essments. The assessment	F 2	78		10/27/17
						1

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F 278	(h) Coordination A registered nurse each assessment was participation of head (i) Certification (1) A registered nurse the assessment is of the assessment is of the assessment must such a that portion of the assessment must such at portion of the assessment must such at portion of the assessment must such assessment must such assessment for the assessment is of the assessment; or the assessment; or the assessment is of the assessment; or the assessment is of the assessment; or the assessment is of the assessment is of the assessment; or the assessment is of the assessm	must conduct or coordinate with the appropriate lith professionals. The se must sign and certify that completed. The sign and certify the accuracy of assessment. The sign and certify the accuracy of assessment. The sign and false statement in a not is subject to a civil money of than \$1,000 for each The individual to certify a material to in a resident assessment is oney penalty or not more than a statement. The sign and document review, the curately code falls according to for the Minimum Data Set sidents (R13, R29) reviewed	F 278	F278 Resident R13, R29 has had modific made to accurately code falls on (FDCRA MDS dated 8/22/17 and SCS MDS dated 8/31/17. (R13) DCRA	(29) SA	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 278	dated 8/22/17, indicinjury since the last 6/6/17. R29's significant chated 8/31/17, indicated 8/31/17, indicatermine if R29 hareentry to the facilit MDS dated 8/31/17 unable to determine 2-6 months from Rif R29 had a fractur months since reent dated 8/31/17 indicated in the facility since in the facility since in the facility since results a bruise to right clavic R29's x-ray results right clavicle. - 7/8/17, at 5:53 p.r bathroom doorway from the fall. - 8/20/17, at 12:45 her room. R29's x-ray left hip.	turn anticipated (DCRA) MDS cated R29 had one fall without assessment period dated assessment period dated ange in status (SCSA) MDS cated the facility was unable to ad a fall one month prior to her y date of 8/25/17. The SCSA also indicated the facility was a if R29 had a fall in the past 29's reentry date of 8/25/17, or a related to a fall in the last six ry on 8/25/17. SCSA MDS ated R29 had been receiving ince 9/28/15.	F 278	dated 8/17/17. For Resident R13 on 08/17/17 a discharge MDS attestation was con 09/28/17 and re-submitted to tha agency. For Resident R29 on 08/22/17 a discharge MDS attestation was con 09/28/17 and re-submitted to tha agency. For Resident R29 on 08/31/17 a si change MDS attestation was compon 09/28/17 and re-submitted to tha agency. All residents require that MDS assessments must accurately refleresident's status. MDS's for all residents with falls in quarter will be reviewed for accura will be modified as needed. Staff involved with MDS will be re-educated on the process of accurated on the process of accurated and audits on an ongoing bas MDS for residents with falls will be conducted by DON/designee to en accurate coding of falls, 2 X week then weekly thereafter. Audit result be reported monthly to the Perform Review team on 10/19/17 and quate full QAPI committee on 11/14/10 QAPI committee will make recommendations for ongoing mor Completion date for F278 is Oct. 2 2017	mpleted e state g. oleted e state ect the the last cy and urately 17. sis of sure X 2, is will nance rterly to 17. The nitoring.	
		rior assessment dated R13				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 278	assessment date 6. indicated the follow -8/17/17, R13 had a of left femur. On 9/21/17, at 1:58 coordinator (MDS)-completed R29's di MDS dated 8/22/17 8/31/17, as well as 8/17/17. After review MDS-C confirmed Finjury on 6/12/17, a and a fall with major confirmed R29's DC section J1900 C sh two falls with major assessment on 6/6. progress notes, MD a fall with major injuconfirmed the DCR J 1800 should have fall since prior asse J1900 C should have fall since prior asse J1900 C should have fall since prior asse J1901 C should have	ogress notes from MDS /15/17, through 8/17/17,	F 2	78			

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F 278	Continued From pa	_	F 278			
F 323 SS=J	State of Minnesota. 483.25(d)(1)(2)(n)(1 HAZARDS/SUPER)-(3) FREE OF ACCIDENT	F 323		10/27/17	
	(d) Accidents. The facility must en	sure that -				
		vironment remains as free ds as is possible; and				
		eceives adequate supervision ices to prevent accidents.				
	appropriate alternate bed rail. If a bed or must ensure corrections	e facility must attempt to use ives prior to installing a side or side rail is used, the facility t installation, use, and I rails, including but not limited nents.				
	(1) Assess the residence from bed rails prior	dent for risk of entrapment to installation.				
		and benefits of bed rails with dent representative and obtain rior to installation.				
	appropriate for the	bed's dimensions are resident's size and weight. IT is not met as evidenced				
	Based on observat review, the facility fa comprehensive falls effective interventio who had a history o	s assessment to determine ns for 1 of 1 resident (R29) f multiple falls and sustained sient practice resulted in		F323 Browns Valley Health Center will co Comprehensive Fall Assessments determine effective interventions for residents with falls. R29 had a Comprehensive Fall Assessment to determine effective	to r	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 323	The immediate jeo R29 had not been the root cause of retransfer and approsimplemented and administrator and contified of the immon 9/21/17. The in removed at 3:39 p. noncompliance rerand severity level, that is not immediate Findings include; Review of R29's sisigned 9/5/17, identified dementiate chronic obstructive recurrent major de R29's quarterly Mir 6/6/17, identified R included dementiate The MDS listed R2 impairment, and rewith dressing, hygilocomotion. Further a fall since the prior R29's significant of identified R29 had required extensive hygiene, eating and with transfers, toile MDS identified the R29 had a fall or from the root of the recommendation of the R29 had a fall or from the root of the R29 had a fall or from the root of the R29 had a fall or from the root of the R29 had a fall or from the root of the R29 had a fall or from the root of the R29 had a fall or from the root of the R29 had a fall or from the root of the R29 had a fall or from the root of the R29 had a fall or from the root of the R29 had a fall or from the root of the R29 had a fall or from the root of the R29 had a fall or from the root of the R29 had a fall or from the root of the R29 had a fall or from the root of the R29 had a fall or from the root of the R29 had a fall or from the root of the	pardy began on 6/12/17, when comprehensively assessed for epeated attempts of self priate interventions was identified on 9/21/17. The director of nursing (DON) were ediate jeopardy at 11:09 a.m. mediate jeopardy was m. on 9/22/17, but mained at the lower G scope which indicated actual harm ate jeopardy. gned Physician Order Sheet, niffied diagnoses which with behavioral disturbance, a pulmonary disease and pression. nimum Data Set (MDS) dated 29 had diagnoses which osteoporosis and depression. Shad severe cognitive equired extensive assistance ene, toileting, transfers and r, the MDS identified R29 had	F 323	interventions to prevent falls on 9/2 As a result of the assessment, the following interventions were added resident's care plan: Celexa was phold, additional Vitamin D, Hipsters applied, Toileting plan was revised, checks between 8p and 8a, and monitoring of attempts to self-trans All residents require adequate supervision and assistive devices the prevent accidents/injuries. Facility Fall Policy was reviewed an revised to include a Fall Analysis where completed on all residents with 2 of falls per quarter, to determine trendersies the care plan. All resident falls in the past 6 month been reviewed to determine a need Comprehensive Fall Assessment. Comprehensive Fall Assessments completed on all residents who have 2 or more falls in the past 6 months for all residents going forward with more falls per quarter a Fall Analys be competed. Charge nurse staff will be re-educated accurate incident reports and fall so investigation reports, the revised fall assessments at the monthly nurse meeting on 10/25/17. Random audit residents with 2 or more falls will be completed by DON/designee on a basis to ensure there is a Fall Analydetermine trends and effectiveness interventions and that the care plan updated. Audit results will be reported weekl IDT team, monthly to Performance	to the out on the out of the out	

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F 323	had sustained a fall 6/12/17, a fall with r with major injury on R29's Fall Risk Car dated 9/7/17, indicated quarter and her mo The CAA further incleft hip fracture from R29 had recent retudepartment was wo precautions remain R29's risk factors for R29's Fall Risk Assidentified R29 had assessment indicat was over 9 was at r Risk Assessments over 9 was at r Risk Assessments over 9 was at r Risk Assessments over 9 was at r Risk for falls due to care plan listed variincluded: use of a loresident did not remassistance with trar to anticipate needs, proper fit, reduced easy reach, no skid on bathroom door to in bed, and safety balarms for resident.	with major injury noted on no injury on 7/8/17 and a fall 8/20/17. e Area Assessment (CAA) ated R29 was at risk for falls. R29 had a history of falls last st recent fall was 8/20/17. Sicated R29 had sustained a note fall. The CAA indicated are from hospital, therapy withing with R29 and safety ed in place. Staff were alert to be fall potential. essment dated 9/7/17, as score of 24. The ed a resident whose score isk for falls. No further Fall were provided by facility. The rent care plan printed on note, last updated 8/21/17, at a R29 had dementia, and was not cognitive deficits. R29's nous interventions which now bed, perimeter mattress, number that she needed inspect shoes/footwear for slip shoes, keep call light in strips in front of toilet, alarm of alert entering, gripper socks need/chair alarms and floor mat	F3	323	Review team on 10/19/17, and quato the QAPI team on 11/14/17. The team will make recommendations ongoing monitoring. Completion date for F323 in Oct. 2 2017	e QAPI for	

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F 323	directed staff to use safety devices includoor TABS and war interventions were I On 9/19/17, at 11: 3 lying in her bed on I a low position, and grab bars in place a had a colored mat I side of her bed and was present on the a white rectangular attached to the left string running from upper back. On 9/20/17, at 2:17 in bed with the head bed was in low positin place and a cond She had a TABS alagrab bar. The string to her shirt with a m shoulder. A black pin place on the left spadded mat was or her bed. On 9/21/17, at 5:28 on her back with ey was in low position There was a black ploor near the left si padded mat on the bed. The TABS alagrab the table of ta	e 2 staff for transfers, and ded alarm BR (bathroom) nderguard. No further fall isted on the care sheet. 33 a.m. R29 was observed her right side. Her bed was in observed to have bilateral and a concave mattress. She ocated on the floor on the right a black pressure floor mat left side of her bed. She had box (TABS alarm unit) grab bar on her bed, with a the box to her shirt on her mid p.m. R29 was observed lying d of bed slightly elevated. The stion. Grab bars were observed ave mattress was on the bed. The arm unit attached to the left g from the unit was attached betal clip on the front of her left oressure floor mat alarm was side of her bed, and a colored of the floor on the right side of the second and had a concave mattress. Oressure floor alarm on the de of her bed and a colored floor on the right side of her right was attached to the red cord leading from the tab	F3	23			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
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Fire reserves in both serves in both	nvestigation Report evealed the following and the following and the following and the following and the report identified lipped while atternational and no injury nearly meeting not cause of fall was proper footwear. The feet and maintenant in the feet and maintenant in the feet and maintenant in the feet and feet an	cident Details/Fall Scene rts from 11/29/16 to 9/18/17, ing: a.m. found on floor next to her selchair was in front of her, I stockings were on her feet. I stockings were on feet and pting self transfer. The report ocks were to be applied at a were utilized at the time of the oted. An IDT (interdisciplinary e dated 12/5/16, identified the as R29 self transferring and Gripper socks were applied to ace was notified to place	F3	23			

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F 323	R29 resident appear that fell under her boff of bed. Evaluat to number of falls. -1/24/17, at 6:50 p. roommate and notion room outside her bodisorientated, appeared wheelchair alarm horesident and not so and a pad alarm pl IDT meeting note croot cause of fall wowheelchair while at had removed TABS was placed in chair alarm. - 2/6/17, at 6:30 p.r near the conference against a geri-chair wheelchair next to	ared to attempt to get bracelet bed when lost balance and fell ion sent to therapy in regards m. staff had been assisting ced R29 on the floor in her athroom. R29 was eared to attempt self transfer, ad been unhooked from bunding. No injuries were noted aced in her wheelchair. An lated 1/30/17, identified the as R29 slipped out of tempting self transfer. R29 alarm from self. Pad alarm as R29 disabled the TABS m. found sitting on the floor the room, with her back leaning r. R29 was disorientated, her, with brakes on. TABS	F3	323			
	removed clip, alarn noted. The report is transferred to a ger front of the confere removed from the conference of the co	ached to resident, resident not sounding. No injury dentified R29 had self ri-chair which was stored in ence room. The geri-chair was common area and properly rence room with doors shut. It was were found. m. found on floor with her all, in her bathroom. R29's normal for her, and had fall ng. She had removed the which had been hooked on the he report listed a secondary foom floor, had not been					

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F 323	discomfort across harea, and a chest x revealed no acute fuse of the secondal IDT meeting note of had taken self to to placed on bathroom self to toilet. An adsurvey) identified that bathroom door a place. The notes di R29 removing alarm -3/28/17, at 7:45 p. room near her bedindicated she was time. Wheelchair at IDT meeting note of had been attempting fell. The note indiction followed, the immewas the use of a TA to alert staff of any clinical record indiction wheelchair had been placed on 1/24/17, 2/6/17, and had been placed on 1/24/17 fall. The not documentation of a disorientated, and the right shoulder was the was also note was also noted.	R29 expressed some ner upper torso and chest ray completed on 2/13/17, findings. Staff educated on the ry alarm, toileting plan. An lated 2/13/17, identified R29 ilet and fell. TABS alarm was an door to alert staff of taking dendum dated 9/20/17, (during ne care plan was not followed alarm had already been in d not address how to deal with	F3	23			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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F 323	after the fall. The refor all transfers with portable x-ray was dindicated a portable fracture of her dista included written state which noted R29 has approximately 6:30 visible bruises and time. The staff state rounds had been cowas sleeping at that pain. A staff written indicated the staff neorning cares on 6 indicated during car arm hurt and staff frand front of her right included written state indicated R29's been low position a week personnel had been Maintenance had do bed needed to be of the lowest position until the nestatement from mai 6/13/17 indicated he approximately 3 incomposition possible, of the bed and installed meeting note dated been noted to have pain in her right should be the composition of the position of the position of the head and she noted to have pain in her right should happened and she nobody had helped	" and denied any assistance port listed staff were to use 2 a gait belt until after the completed. The report ex-ray done identified a I right clavicle. The record tements from staff dated at been assisted to bed at p.m. on 6/11/17 and had no no complaints of pain at that ement indicated 5:00 a.m. ompleted on 6/12/17 and she time and no complaints of statement, dated 6/13/17 nember had assisted R29 with 1/12/17. The statement res, R29 had indicated her ound bruises on her shoulder at leg. The record also tements from 6/13/17, which had been unable to be put in prior and maintenance in notified of the broken bed. etermined new parts for the redered, and adjusted the bed on, and would remain in that we part installed. The written intenance personnel dated	F3	323		

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	PROVIDER OR SUPPLIER S VALLEY HEALTH C	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 114 JEFFERSON STREET SOUTH BROWNS VALLEY, MN 56219	-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 323	noted, no further ar or function of the sabeen completed. - 7/8/17, at 8:55 a.m. side on the floor, in resident's bathroom unhooked her alarm assistance, remove and was in stocking TABS alarm pressure wheelchair to alert meeting note dated found crawling on the resident's bathroom no injury, and care immediate interven a pressure pad in his self transfers. No furth documented. Howe indicated a pad alar wheelchair after the facility having known removed/unhooked R29's fall intervention been completed. -8/20/17, at 12:45 a found R29 on the fli walker in her room, indicated she was good "buff the floor." The been observed earling off herself. R29 de The report indicated out of resident sight.	_	F 3	23			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245564	B. WING _		09	/22/2017	
	PROVIDER OR SUPPLIER S VALLEY HEALTH C	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 114 JEFFERSON STREET SOUTH BROWNS VALLEY, MN 56219			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 323	left leg and hip area was unwilling to tra that time, identified fracture of the left f degrees varus angifragment. An IDT n identified staff note TABS alarm earlier delusional and was The note indicated was to reapply the she could not remoindicated on 8/21/1 leg and hip pain, gutransfer. Further, the been transferred to left hip fracture. The plan had been follo R29's fall was docu R29's repeated rem	atted she had discomfort in her a, guarding of the area and nsfer. A x-ray completed at an acute intertrochanteric emur associated with 90 ulation of the femoral shaft neeting note dated 8/22/17, d that R29 had removed her in the shift and was talking unsettled earlier in the shift. the immediate intervention TABS alarm and place where we it herself. The note 7, R29 had complained of left parded leg and was unwilling to be note indicated R29 had the hospital for evaluation of a e note indicated R29's care wed. No further analysis of imented. However, despite noval/unhook of alarms, no had been implemented prior to	F 3:	23			
	9/20/17, revealed the -11/29/16, at 1:30 a sitting next to bed, brakes not locked. feet, gripper socks	a.m. R29 was found on floor, wheelchair in front of her, Denied pain. Was in stocking applied. Maintenance notified strips next to her bed. Hourly					
	floor next to her be and shoes. Her wh Denied pain. R29 in	p.m. R29 was found sitting on d. Was wearing gripper socks neelchair was behind her. ndicated she was reaching for pwards nightstand. Put back					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245564	B. WING			09/22/2017	
	PROVIDER OR SUPPLIER S VALLEY HEALTH C	ENTER		STREET ADDRESS, CITY, STATE, ZIP 114 JEFFERSON STREET SOUTH BROWNS VALLEY, MN 56219	CODE		-
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		N SHOULD E E APPROPRI	3E	(X5) COMPLETION DATE
F 323	found R29 on the f R29 indicated her with under bed and four placed bracelet on -12/6/16, at 7:39 a. with safety interver this quarter. Last faperimeter mattress -12/12/16, at 1:30 pcompleted. R29 was therapy services. Find multiple falls a interventions in pla -1/16/17, Discontin Restorative AROM motion)/Toileting proceedings of the banded. Placed a pafall identified alarm -2/6/17, at 7:23 p.n sitting on floor with Geri-chair with whe brakes on. R29 has alarm and it was not Geri-chair removed properly stored in coshut.	m. staff heard loud sound, loor in front of her nightstand. wrist and rubbed it. Looked and bracelet, retrieved and R29's wrist. No injury noted. m. R29 identified as fall risk ations in place. Has had falls all 12/4/16. Grab bars and used. c.m. Therapy evaluation as appropriate for activity deview of R29 identified she and review of safety ce completed. ued from active therapy.	F3	323			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245564	B. WING			09/3	22/2017
	PROVIDER OR SUPPLIER S VALLEY HEALTH C	ENTER		11	TREET ADDRESS, CITY, STATE, ZIP CODE 14 JEFFERSON STREET SOUTH ROWNS VALLEY, MN 56219		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	Message left for pri3/13/17, at 1:35 p. quarter. Last fall wa R29 had severe co BIMS score of 5. F last 3 months and a R29 has history of of The follow up x-ray -3/20/17, at 4:31 p. recognized objects recognize place, tin -5/21/17, at 1:49 p. R29's safety device assessment indicat Does wander in wh asking for help and transfer in and out using an alarm on b used in bed, wheele program remains in alarms in plan of ca -6/8/17, at 2:14 p.m falls this quarter, la interventions in place impairment and dis Last noted fall from had a perimeter ma to bowel and bladde interventions. No cl care6/12/17, at 8:15 a squeezed right sho	st pain and mid area sharp. Imary physician. m. R29 had falls in last as 2/12/17. Note indicated gnitive impairment with a R29 has rolled out of bed in the a perimeter mattress is used. Inchest pain from previous fall. Indicated no fracture. m. note indicated R29 and people, but did not ne or situation m. note indicated a review of es was completed. Falls risk and she was at risk for falls. Indicated and chair. Currently contained and chair. Currently contained and lift chair. Toileting a place. Will continue usage of are. a. At risk for falls, R29 had had ast fall 3/28/17, and safety and was 3/28/17, and R29 attress in place. No changes attress in place. No changes	F3	323			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245564	B. WING		· · · · · · · · · · · · · · · · · · ·	09/:	22/2017
	PROVIDER OR SUPPLIER S VALLEY HEALTH C	ENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 14 JEFFERSON STREET SOUTH BROWNS VALLEY, MN 56219		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOL TAG CROSS-REFERENCED TO THE APPRODEFICIENCY)		BE	(X5) COMPLETION DATE
F 323	site. A scrape was knee. R29 stated sasked if anyone he no. R29's primary orders were received. Two staff assistance transfer belt until Plant of the contract of distal rigphysician was notifed. The contract of distal rigphysician was notifed. The contract of distal rigphysician was notifed. The contract of distal rigphysician was called clavicle strap to use physician was called clavicle strap to use physician therapy massafe transfers. The contract of the	elling was noted around the noted also below R29's right she fell when asked, and when liped her she shook her head physician was notified and ed for a PPX (portable x-ray). e for R29 with all transfers and PX completed. m. results of x-ray indicated ht clavicle. R29's primary ied. m. R29 had increased difficulty incident. R29's primary d and new orders received for e as needed for comfort and ay evaluate and treat to direct m. A care conference was held ments were completed. ted falls, wanderguard, ms, bed low, anti-roll backs. Intation related fall assessment o.m. R29 was very anxious and at the doors of the facility. was her home. n. R29 was up in her :10 a.m. to 2:00 a.m. R29 had the north and south doors and	F3	323			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		245564	B. WING _		09	/22/2017	
	PROVIDER OR SUPPLIER S VALLEY HEALTH C	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 114 JEFFERSON STREET SOUTH BROWNS VALLEY, MN 56219			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUTH	OULD BE	(X5) COMPLETION DATE	
F 323	occupational therappost clavicle fracture -7/8/17, at 5:53 p.m resident's bathroom side. R29 had rem her TABS alarm. It pressure alarm was seat. Further, the nalarms do not preveresident whereabout included as care plutherefore is not rep -7/12/17, at 11:55 a activity tolerance, smore difficulty. R2s recent fracture. Or evaluate and treat. -7/26/17, at 10:14 secured to wall. Cadiscontinued and replace. -8/16/17, at 5:38 a. from 1:00 a.m. to 3 R29 told the writer syrup, but she did relobby and watched.	by to evaluate and treat for re. 1. R29 was in another of doorway lying on her right oved her shoes and removed to injury noted. A TABS is placed in her wheelchair ote included "Remember, ent falls, they just alert staff to uts, so if not alarming, is not an not being followed, ortable." 1. I.M. R29 had declined in trength, and transfers were the was unable to walk since ders received for therapy to a.m. Chest of drawers was re plan was followed. 2. I.M. active therapy services estorative program remained in the man active therapy services estorative program remained in the man active therapy services estorative program remained in the man active therapy services estorative program remained in the man active therapy services estorative program remained in the man active therapy services estorative program remained in the man active therapy services estorative program remained in the man active therapy services estorative program remained in the man active therapy services estorative program remained in the man active therapy services estorative program remained in the man active therapy services estorative program remained in the man active therapy services estorative program remained in the man active therapy services estorative program remained in the man active therapy services estorative program remained in the man active therapy services estorative program remained in the man active therapy services estorative program remained in the man active therapy services estorative program remained in the man active the man active therapy services estorative program remained in the man active therapy services estorative program remained in the man active therapy services estorative program remained in the man active therapy services estorative program remained in the man active therapy services estorative program remained in the man active the man act	F 32	3			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245564	B. WING			09/22/2017	
	PROVIDER OR SUPPLIER S VALLEY HEALTH C	ENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 14 JEFFERSON STREET SOUTH BROWNS VALLEY, MN 56219		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	then back to bed an -8/20/17, at 12:30 a ringing and R29 informs and R29 informs activated. Call light -8/20/17, at 12:45 a coming from R29's outside of her roomher room. R29 stated and R29 stated and R29 was obsetime. Informed she and R29 continued Alarm moved out or -8/20/17, at 4:37 a. were on and not with discomfort. -8/21/17, at 8:30 a. pain when she was was guarding her lephysician was notifit received. -8/21/17, at 1:00 p.12 hours and was rowas applied for compain with reposition and hip area.	as assisted to the bathroom and alarms were activated. a.m. R29's bed alarm was ormed staff that she had becked R29 and found no arm and floor mat were was within reach. a.m. staff heard a noise room. She was on the floor and her walker was inside sed she was going to shut the cor. R29 sustained a 2 and her head and denied as applied. R29 was assisted sistance of 2 staff and gait erved to unhook alarm at this a needed to keep the alarm on to play with alarm buttons.	F3	323			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		245564	B. WING			09/	22/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 114 JEFFERSON STREET SOUTH BROWNS VALLEY, MN 56219	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD I HE APPROPR	BE	(X5) COMPLETION DATE
F 323	fracture of left hip. notified. Orders for catheter, to keep to oral intake) after me surgery in the more of left femurity in the more orders received, in and OT (occupation treat. -8/26/17, at 6:11 at 8/23/17, PT evaluate transfers. -8/29/17, at 3:59 at judgement and did bed alarm, floor palight was within received including Safety indicated far bed/chair/floor ala further documental assessment of R2 -9/1/17, at 3:30 pulimpairment. R29's with recent hip fra experienced lethal -9/5/17, at 11:41 and -9/5/17, at 8:50	p.m. x-ray results indicated R29's primary physician was r foley indwelling urinary resident on bed rest, NPO (no nidnight and to transfer for rning. o.m. R29 returned from hospital ure and left hip fracture. New noluding PT (physical therapy) onal therapy) to evaluate and o.m. R29 had left hip pinned on ation 8/25/17. Hoyer lift for all o.m. R29 exercised poor of not use call lights. Low bed, ad in place and activated. Call ach. o.m. care conference was day assessments were of R29's comprehensive report.	F3	323			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245564	B. WING			09/22/2017	
	PROVIDER OR SUPPLIER S VALLEY HEALTH C	ENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 114 JEFFERSON STREET SOUTH BROWNS VALLEY, MN 56219		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	transfers and she widentified as at risk potential as recent.	ce. Hoyer used for R29's vas unable to walk. R29 for falls. Staff noted fall risk	F3	323			
	day assessments re Comprehensive Re bed/chair/floor alarr	eviewed including Resident port. Fall, wanderguard, ms, bed low, anti-rollbacks. No ion of R29's fall assessment					
	-9/8/17, at 3:15 p.m and R29 appropriat	n. PT evaluation completed te for active therapy services.					
	registered nurse (R						
	trying to climb out of the wheelchair with staff. R29 refused time. Acetaminopho given to the resider R29 was unable to	m. R29 was restless and of bed. R29 was assisted up to extensive assistance of 2 to go to the bathroom at that en 325 mg X 2 tablets were at for right hip and leg pain. rate pain, and her incision site R29 was given pudding for a					
	devices currently in Note indicated to comeet her safety nee R29 was not active strings/devices. R2 to meet her needs.	m.(during survey) R29's safety place were reviewed by IDT. ontinue to problem solve to eds. Staff interview indicated ly pulling at alarm 29's plan of care was modified R29 was being seen by ices. Screen was to be sent to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245564	B. WING			09/2	22/2017
	PROVIDER OR SUPPLIER S VALLEY HEALTH C	ENTER		11	FREET ADDRESS, CITY, STATE, ZIP CODE 4 JEFFERSON STREET SOUTH ROWNS VALLEY, MN 56219		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	During interview on indicated the last tir attempted to take the weeks ago, "maybe on 9/20/17, at 2:02 utilized a TAB alarm R29 and she also he door. She stated R29 indicated R29 had repast, but was not at on 9/20/17, at 2:19 utilized a TAB alarm wheelchair which sishirt. She indicated her alarm in awhile added a pressure fle fracture. R29 utilized on the side near the seen her get out of on 9/20/17, at 2:38 watched R29 for fall	urrent safety in place and aide with meet R29's needs. 9/20/17, at 1:39 p.m. NA-A me she was aware R29 ne alarm off was several a month or two ago." p.m. NA-D indicated staff in her bed and wheelchair for ad an alarm on her bathroom 29 did not use her call light. was at risk of falls. She removed her alarms in the ware of her doing it lately. 9 p.m. NA-E indicated R29 in connected to her bed or raff clipped to the back of her R29 had not tried to remove is She indicated the facility had oor mat alarm after her id a cushioned pad on the floor window, but she had never bed on that side. 8 p.m. NA-C indicated staff ills. He indicated R29 utilized a	F3	23	DEFICIENCY)		
	transferred. He indi transfer at least one time he was aware last evening at appr heard the floor alare	cated he was aware R29 self cated R29 attempted to self be a day, and the most recent of R29's self transfer was the roximately 7:00 p.m., when he m pad sound. NA-C indicated could remove the TAB alarm					

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	PROVIDER OR SUPPLIER S VALLEY HEALTH C	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 114 JEFFERSON STREET SOUTH BROWNS VALLEY, MN 56219			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 323	On 9/20/17, at 2:49 with RN-A and licer RN-A indicated LPI assessments for the last fall risk assess 9/7/17, and she socianything over 9 ind of falls. RN-A state broke her clavicle as most recent fall. She made many changes taff needed to pro R29. RN-A indicate routinely in a week identified as a intertime, interventions were made as need documented the more resident's chart. However, the fall so IDT meetings failed R29's risk for falls to trends/patterns to for causing the falls, a interventions. On 9/20/17, at 3:04 R29's clavicle fract staff to 2 assist with living) and the floor added after her hip had severe cognitive hallucinations and ireliable historian re R29's clavicle fract she felt R29 was right to the resident of the recognition o	p.m. during group interview need practical nurse (LPN)-A, N-A completed fall e facility. RN-A indicated her ment had been completed on ored 24, and a score of icated the resident was at risk and R29 had fallen in June and and fractured her hip with her ne indicated the facility had ses to R29's care plan because vide much more assistance to ad the facility reviewed falls by therapy meeting which she disciplinary meeting. At that were reviewed and changes ded. RN-A indicated the facility eeting in a IDT note in each cene investigation forms and do to comprehensively assess to include but not limited to alls, factors that may be not effectiveness of the p.m. LPN-A indicated after the facility had increased in ADLs (activities of daily pressure alarm had been fracture. RN-A confirmed R29 we impairment, history of indicated she felt R29 was a lated to the incident when ure was found. RN-A indicated ght on and sometimes she was unitive status was intermittent.	F 323				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245564	B. WING		09	/22/2017
	PROVIDER OR SUPPLIER S VALLEY HEALTH C	ENTER		STREET ADDRESS, CITY, STATE, 114 JEFFERSON STREET SOU BROWNS VALLEY, MN 562	ZIP CODE JTH	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 323	communicate effectivas aware R29 had alarm and continue indicated she felt R1 hour checks, and toileting patterns in were in R29's room roommates condition put in a formal programmed R1 indicated her care princlude applying the she could not remoon 8/22/17. The DC have been updated During review of R2 with surveyor, the Dinconsistencies with the placement of the unable to explain the placement of the care felt that was the real she indicated she are removed because in the placement of the placement	tively. LPN-A indicated she did a history of removing her did to remove her alarms. RN-A 29 would not be candidate for she had no consistency with the past. RN-A stated staffication, because of her on, but the facility had never tram for R29 safety checks. p.m. director of nursing 29's current care plan and plan should of been updated to et TABS alarm in a place where ever it when this was discussed and the NAR care sheet. 29's electronic health record and the computer data related to be clip for the alarms and was the inconsistencies. At 4:29 the had been made aware of the plan made at that time, and alson for the inconsistencies. Assumed the intervention at of the clip for alarm was the was no longer effective. Between the did talked with staff and the no longer tried to remove her that intervention was no longer med R29 was restless, but the had not tried to remove her ear. DON stated she was not ansfer attempt documented in the computer of the clip for alarm was not ansfer attempt documented in the computer of the clip for move her ear.	F3	323		

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ID PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245564	B. WING _		09	/22/2017
	PROVIDER OR SUPPLIER S VALLEY HEALTH C	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 114 JEFFERSON STREET SOUTH BROWNS VALLEY, MN 56219		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 323	sometimes restless had slept very well slept better last nig out of the room dur the roommate woul R29. RN-B indicated try to self transfer sindicated she was a R29 continued to a fractured hip. She i R29 attempt to self week prior, when slegs back into bed. and indicated R29 awhat staff say to he RN-B indicated the attempted self transwhen a nursing stattransfer. RN-B indicated the attempted self transwhen a nursing stattransfer. RN-B indicated her fracility had implement and stated R29's flof for a few months, blong it had been uti aware R29 knew he and that she had shalarm. She indicated herself every other indicated R29 was to know if she under her normal state. On 9/21/17, at 5:54 (TMA)-A indicated and indicated R29 indicated R29 had lend to the result of the room and the room all state.	In a.m. RN-B stated R29 was at night and indicated R29 at present. RN-B felt R29 had hit because her roommate was ing the night. RN-B indicated d make noise and wake up d she had not witnessed R29 ince her fractured hip, but she aware other staff had reported trempt self transfers since her indicated she had witnessed transfer approximately one he assisted R29 to put her She stated R29 had dementia at times would understand or and at other times not. Last time she was aware R29 after was earlier that night finformed her of the self cated R29 utilized a floor and she indicated the facility requently. RN-B stated the ented hourly checks last night for alarm had been in place but was unsure exactly how lized. RN-B indicated she was ow to take her TABS alarm off the pressure floor d R29 took the TABS alarm off day or every third day. RN-B confused at times, was difficult erstood and indicated that was a.m. trained medication aide R29 utilized a TABS alarm always took it off. She been able to remove the clip of our wherever it was placed.	F 3:	23		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION UNG		(X3) DATE SURVEY COMPLETED		
		245564	B. WING			09/2	22/2017
	PROVIDER OR SUPPLIER S VALLEY HEALTH C	ENTER		STREET ADDRESS, CITY, STATE, ZIP 114 JEFFERSON STREET SOUTH BROWNS VALLEY, MN 56219	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		N SHOULD E APPROPF	BE	(X5) COMPLETION DATE
F 323	TMA-A indicated R2 alarm and stated th long time, and the f floor had been used TMA-A indicated sher bathroom to ale R29 had confusion few words. TMA-A get up on her own, the edge of the bed On 9/21/17, at 5:46 confused, utilized a had been in place pindicated she was r self transfer since so On 9/20/17, at 6:00 confused andhe was self transfer the nig indicated she saw a wanted to get up ar been assisting R29 occurred. NA-H sta sounded yet, but sa and last night was that attempt he was away on 9/21/17, 6:38 a. facility practice when charge nurse to assif injury was present She then would lood determining cause immediate intervent on Mondays the fact meetings and falls and documentation	29 also had a pressure floor e alarms had been in place a loor pressure alarm on the d for R29 6 months or more. He also had a door alarm on ert staff also. TMA-A indicated and communicated in only a stated R29 sometimes tried to and she could get herself onto d. a.m. NA-G indicated R29 was floor pressure alarm, which prior to the fractured hip. She not aware R29 had attempted the had her hip fracture. a.m. NA-H stated R29 was as aware R29 had attempted the had her hip fracture. a.m. NA-H stated R29 was as aware R29 had attempted the before, when she had a girl running around and find her. He stated he had the alarm had not have her attempting to get up the most recent self transfer	F3	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245564	B. WING		09	/22/2017		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 114 JEFFERSON STREET SOUTH BROWNS VALLEY, MN 56219	CODE •			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 323	stated the facility of assessments for a returns and changishe had assisted wincident on 6/12/17 fracture. She indicinterviewed R29 arquestions at that ti was initiated, a cla assistance of 2 state contained. She state 7/8/17, and stated in R29's wheelcha R29 was confused delusional earlier of indicated she thou was initiated when hospital. After revidated 8/20/17, at 1 confirmed the presprior to the fall on 80 on 9/21/17, at 7:00 a little confused, after a long as she the pressure floor since she broke he current NAR care is tabs alarm or specific transfer at least on On 9/21/17, at 7:10 printed NAR care is confirmed R29's confir	all assessments and LPN-A ompleted comprehensive fall dmissions, annually, hospital e of conditions. She indicated with the investigation of R29's 7, which resulted in the clavicle cated another nurse had and R29 was able to answer me. LPN-P indicated therapy vicle brace was utilized and aff for transfers were ted R29 had another fall on a pressure alarm was placed at times and verified R29 was on the shift of 8/20/17. LPN-A ght the pressure floor alarm R29 returned from the ew of R29's progress note 2:30 a.m. with surveyor, she assure floor alarm was in place 3/20/17. If a.m. NA-I indicated R29 was and had a TABS alarm in place worked at facility and thought mat had been implemented er hip. She confirmed the sheet did not include use of the iffic directions on how to place licated she had not witnessed ince she broke her hip. She nat, R29 would attempt self	F3	23				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245564	B. WING			09/:	22/2017
	PROVIDER OR SUPPLIER S VALLEY HEALTH C	ENTER		114	REET ADDRESS, CITY, STATE, ZIP CODE JEFFERSON STREET SOUTH OWNS VALLEY, MN 56219		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	had talked with R29 bruises on her shout told her she "fell", a no one assisted her up. She indicated shousing on R29 was on 9/21/17, at 7:37 practiced was to do meetings for specific report. She indicated incidents reviewed titled BVHC Therap documentation of a 6/12/17 fall had not R29 had been reviet 7/8/17 and 8/20/17 R29 unhooking her status and medical cause of R29's 7/8/ was found on the fluoted earlier she was confused. DON intervention implementation the TABS alaremove herself. She interventions were in DON stated the usucharge nurse to constaff involved were statements of the indetermined if the in On 9/21/17, at 8:05 usual facility practic complete the compand the MDS coordinates.	vening. RN-A confirmed she after she was noted to have alder and indicated R29 had not had not asked for help and r and it was hard for her to get he felt the cause of the s from the reported fall. a.m. DON stated her usual cument minutes of the IDT ic residents in the incident of she maintained a log of at the meetings, on a form y meeting and confirmed review of R29 after the been done and confirmed ewed in the meeting after her falls. At 8:00 a.m. DON stated alarm, footwear, toileting status was found to be the 17 fall. She confirmed R29 for on 8/20/17 after staff had as removing her alarms and a indicated the immediate lented at that time was to the exercise of further mplemented at that time. The fall facility practice was for the mplete an incident report and to complete witness accident. The DON was notified, cident was a reportable event.	F3	23			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245564	B. WING			09/:	22/2017
	PROVIDER OR SUPPLIER S VALLEY HEALTH C	ENTER		11	TREET ADDRESS, CITY, STATE, ZIP CODE 14 JEFFERSON STREET SOUTH ROWNS VALLEY, MN 56219		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOSE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	incident report, utili to gather informatic IDT would review the She indicated the I information sooner R29's current care She confirmed R29 herself on 7/8/17 at 1:54 comprehensive fall significant change indicated she had refall assessments we provide any further assessments comprehensive fall assessments we provide any further assessments comprehensive for indicated fall assessments comprehensive for indicated distal end of the classification of the classi	nurse would complete the zed the fall investigation form on for the report and then the he fall at the routine meetings. DT would review the if needed. DON confirmed plan and NAR care sheets. It had removed the alarms and 8/20/17. It p.m. RN-A confirmed the assessment done with the MDS CAA on 9/7/17. She reviewed R29's comprehensive with DON and was unable to comprehensive fall pleted for R29. In physician's progress notes are revealed the following: It revealed the following: It revealed the following: It alkative but she denied ach pain, no back pain, no allen today, but was not hurt. In nondisplaced fracture of the avicle and that is ok. It alien today have the denied ach pain, no have the following of systems really not reliable not respond much, but	F3	23			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		245564	B. WING _		09/	22/2017	
	PROVIDER OR SUPPLIER S VALLEY HEALTH C	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 114 JEFFERSON STREET SOUTH BROWNS VALLEY, MN 56219			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 323	physical dated 8/22 systems unobtainal dementia. Due to the benefits and alternature if the patient anything at this stage. -Prairie Lakes Heal summary dated 8/2 dementia, so unforwill answer when we have will answer when we have will answer when we have being to be a significant change of the top revent reoccurrent patterns. A fall risk completed upon adsignificant change of triggered, on a 90 cany time a restraint possible, within 48-team would complete accident/incident for probable causes of further recommend and causes have beinterventions that we nursing and or interventions that we nursing and or effective to the top to be accident for effective to the top top top top top the top	Ithcare System history and 2/17; indicated review of ble due to the patient's he patient's dementia, risks, atives were discussed but it is truly understanding ge. Ithcare System discharge 25/17, She does have chronic tunately is limited on what she re ask he questions. Ity policy titled St. Francis Morris Accident/Incident anded on 4/16/15 identified bedures that adequately eat and prevent accidents and are resident at risk for injury. The IDT team to determine the incident, the best approaches ence and identify trends and assessment would be mission, hospital returns, of condition, if falls are day review, annual review and awas applied. As soon as 72 hours the Interdisciplinary	F 32	23			

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

PRINTED: 10/24/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245564	B. WING		09/	/22/2017
	PROVIDER OR SUPPLIER S VALLEY HEALTH C	ENTER		STREET ADDRESS, CITY, STATE, ZIP 114 JEFFERSON STREET SOUTH BROWNS VALLEY, MN 56219	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 323	was necessary, it could follow up section or necessary this wou approximately a weassessment was concerned assessment was concerned assurance team idea trends, measures with identified areas. The immediate jeon was removed on 9% comprehensively assimplemented effect the facility fall policity be completed after trends and revise the lintervention changes Celexa put on hold hourly checks between tracking log for alar toileting plan was a scheduled toileting non compliance removed on 9% comprehensively assimplemented effects the facility fall policity in the facility fall policity fall polici	an be documented on the in the form. If follow up was lid be done by the IDT in sek from the date the team ompleted. If follow up is an a week, this would be form as well. If the quality entifies significant causes or will be taken to correct the orardy that began on 6/12/17, 22/17, when the facility essessed R29 for falls, ive interventions and revised es to include a fall analysis to 2 or more falls to determine the care plan as needed. The made for R29 included: In vitamin D added, hipsters, the en 8 p.m. and 8 a.m. and a sem activations for R29. R29's lso revised to include during the night hours. The mained at the lower scope and the data and actual harm had	F3	23		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered October 4, 2017

Ms. Autumn Roark, Administrator Browns Valley Health Center 114 Jefferson Street South Browns Valley, MN 56219

Re: State Nursing Home Licensing Orders - Project Number S5564027

Dear Ms. Roark:

The above facility was surveyed on September 18, 2017 through September 22, 2017 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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. 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.

Browns Valley Health Center October 4, 2017 Page 2

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 Gail Anderson at (218) 332-5140 or email: gail.anderson@state.mn.us.

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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meeth

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us

Phone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	(X3) DATE SURVEY COMPLETED		
		00668	B. WING		09/22/2017
				ETATE, ZIP CODE EET SOUTH N 56219	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
2 000	Initial Comments		2 000		
	****ATTEN	NTION*****			
	NH LICENSING	CORRECTION ORDER			
	144A.10, this correct pursuant to a surve found that the deficit herein are not corrected shall I with a schedule of the Minnesota Department of which is a schedule of the Minnesota Department of the corrected requires of requirements of the number and MN Ru When a rule contain	nether a violation has been			
	lack of compliance. re-inspection with a result in the assess	Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was			
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.			
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/infe licensing orders are			

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

Electronically Signed 10/11/17

TITLE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00668	B. WING		09/2	2/2017
				ETATE, ZIP CODE EET SOUTH N 56219		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 000	Department of Hear you electronically. Is necessary for State enter the word "corn text. You must then State licensure proceed completion date, the corrected prior to el Minnesota Departm. On September 18, surveyors of this Deabove provider and orders are issued. electronic plan of coreviewed these ordethey will be completed. Minnesota Departmente State Licensing federal software. Tates assigned to Minnesota Departmente State Licensing federal software. Tates assigned to Minnesota Departmente State Licensing federal software. Tates assigned to Minnesota Departmente and replaces the "Incorrection order. The assigned tag in column entitled" ID statute/rule out of complete statements. The statement, evidence by." Followare the Suggested Time period for Cornesotron Cornesotro Co	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the ment of Health. 19, 20, 21 & 22, 2017 epartment's staff, visited the the following correction Please indicate in your correction that you have ers, and identify the date when ted. Inent of Health is documenting Correction Orders using ag numbers have been onta state statutes/rules for umber appears in the far left of Prefix Tag." The state compliance is listed in the ent of Deficiencies" column to Comply" portion of the nis column also includes the n violation of the state statute in This Rule is not met as wing the surveyors findings Method of Correction and crection. IRD THE HEADING OF THE	2 000			
	"PROVIDER'S PLA	N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY.				

Minnesota Department of Health

STATE FORM 6899 NJ3911 If continuation sheet 2 of 49

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED	
		00668	B. WING	····	09/2	22/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BROWN	S VALLEY HEALTH C	FNIFR	ERSON STR VALLEY, M	EET SOUTH N 56219		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	THIS WILL APPEA	R ON EACH PAGE.				
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 545	MN Rule 4658.0400 Resident Assessme	O Subp. 3 A-C Comprehensive ent; Frequency	2 545			10/27/17
	assessments must A. within 14 day B. within 14 day the resident's physic	by. Comprehensive resident be conducted: s after the date of admission; is after a significant change in cal or mental condition; and every 12 months.				
	by: Based on interview failed to complete a Assessment (SCSA change in resident s Minimum Data Set	and record review, the facility Significant Change in Status When two or more areas of status were noted on the (MDS) for 1 of 1 resident activities of daily living.		Corrected		
	Findings include:					
	R13 had intact cograssistance from two and toileting. R13 h motion, did not requoccasionally inconti	S dated 6/15/17, indicated nition and required extensive o staff for transfers, dressing ad no limitation in range of uire oxygen and was nent of bowel. R13 also had t she was unable to rate and ior assessment.				
		ective Payment System (PPS) , indicated R13 had moderate				

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00668	B. WING		09/2	2/2017
NAME OF PRO\	VIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BROWNS VA	ALLEY HEALTH C	FNTFR	ERSON STR VALLEY, MI	EET SOUTH N 56219		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
cog ass tra fur inte R1 oxy sui fre on dis con dia R1 had tota dre lim dai fre an wo had fra Re de implaced dre con on fra fra fra fra fra fra fra fra fra fra	sistance from two nsfers, dressing nctional limitation erfered with daily 3 was frequently ygen and had a s rgical wound care quently having m e fall with a majo slocations, closed nsciousness, sub agnosis of a fracto 3's quarterly MD d moderate cogn al assistance from essing, and toiletin itation in range of illy functions to a rquently incontine d had a surgical bund care. R13 in ving moderate paracture other than eview of the above cline in cognition paired, increase itivities of daily livit essing and toiletin nge of motion that a lower extremity ntinence, increase in falls, ne surgical wound c	ant and required total of staff for bed mobility, and toileting. R13 had a in range of motion that in functions to a lower extremity. Incontinent of bowel, required surgical wound that required extra indicated she was noderate pain. R13 also had in injury (bone fractures, joint I head injuries with altered odural hematoma) with a sure other than a hip fracture. S dated 9/3/17, indicated R13 intive impairment and required in two staff for transfers, ing. R13 had a functional of motion that interfered with lower extremity. R13 was ent of bowel, required surgical dicated she was frequently ain and had a diagnosis of a	2 545			

Minnesota Department of Health

STATE FORM 6899 NJ3911 If continuation sheet 4 of 49

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00668	B. WING		09/2	2/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BROWN	S VALLEY HEALTH C	FNTFR	ERSON STR VALLEY, MI	EET SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 545	dated 9/3/17. MDS discharge return an 8/17/17 was completed. Assess manual directed who nursing home after determine if criteria if the criteria are mecompleted. She alsindicated the need assessment when twere noted and not 14 days. MDS coor hospitalization staff Monday morning the did not require a So stated there was a decision in R13's manual director of nursing (facility as the previous "Reviewed on return ADL had not chang decrease as Fx [frate to do a Significant of at this time". Facility provided poservices of Morris I reviewed date of 4/conduct a compreh standardized assess functional capacity, regulations, Rules at the Centers for Med State of Minnesota.	coordinator confirmed a ticipated (DCRA) MDS dated eted for R13. She confirmed sment Instrument (RAI) hen a resident returned to the a DCRA MDS, the IDT must are met for a SCSA MDS and et, a SCSA MDS must be o agreed the RAI manual for a significant change two or more areas of change expected to be self-limiting to dinator stated after the met to discuss R13 at the erapy meeting and felt R13 CSA MDS. MDS coordinator progress note stating the hedical record. In note dated 8/21/17 indicated /17 was made on 9/18/17 by who was identified by the pus MDS coordinator) stated: In from hospital that resident ed and pain is expected to be caused in status assessment. Ilicy titled, St. Francis Health MDS 3.0 Assessment, with a 6/15, indicated "Policy: To ensive, accurate and sament of each resident's using the RAI manual and and Status [sic] specified by dicare and Medicaid and the	2 545			

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00668	B. WING		09/2	2/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
BROWNS	BROWNS VALLEY HEALTH CENTER BROWN			EET SOUTH N 56219		
(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 SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 545	Continued From pa	ge 5	2 545			
	dated 10/16, included the definition of a significant change as a decline or improvement in a resident's status that:					
	intervention by staff disease-related clin 'self-limiting' (for de 2. Impacts more that health status; and	an one area of the resident's ciplinary (IDT) review and/or				
	determined that a s the nursing home s identification of the clinical record. The constitutes a signification based upon the jud clarified that MDS a	directed when the IDT ignificant change occurred, hould document the initial significant change in the final decision regarding what cant change in status must be gment of the IDT. The manual assessments are not required ary variations in resident				
	director of nurses (I training to nursing s re-assessment afte change in status. A ensure the required assessments are in	nplemented accurately and could be reported to the				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.0520 Proper Nursing Car	Subp. 1 Adequate and e; General	2 830			10/27/17

Minnesota Department of Health

STATE FORM 6899 NJ3911 If continuation sheet 6 of 49

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			71. 5012511143.			
		00668	B. WING		09/2	2/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BROWN	S VALLEY HEALTH C	ENTER	ERSON STR VALLEY, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 6	2 830			
	receive nursing carcustodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident in bed.				
	This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to conduct a comprehensive falls assessment to determine effective interventions for 1 of 1 resident (R29) who had a history of multiple falls and sustained fractures. This deficient practice resulted in immediate jeopardy for R29.			Corrected		
	R29 had not been of the root cause of re- transfer and approprimplemented and wadministrator and donotified of the immedian 9/21/17. The im- removed at 3:39 p. noncompliance rem	vas identified on 9/21/17. The lirector of nursing (DON) were ediate jeopardy at 11:09 a.m. amediate jeopardy was m. on 9/22/17, but nained at the lower G scope which indicated actual harm				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00668	B. WING		00/2	09/22/2017	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	09/2	2/2017	
BROWN	S VALLEY HEALTH C	ENTER 114 JEFFI		EET SOUTH			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 830	Continued From page 7		2 830				
	signed 9/5/17, iden included demential chronic obstructive recurrent major dep R29's quarterly Min 6/6/17, identified R2 included dementia, The MDS listed R2 impairment, and rewith dressing, hygie	imum Data Set (MDS) dated 29 had diagnoses which osteoporosis and depression. 9 had severe cognitive quired extensive assistance ene, toileting, transfers and r, the MDS identified R29 had					
	R29's significant change MDS dated 8/31/17, identified R29 had severe cognitive impairment, required extensive assistance with dressing, hygiene, eating and locomotion, total assistance with transfers, toileting and did not walk. The MDS identified they were unable to determine if R29 had a fall or fracture since the prior assessment. The MDS also identified R29 had no falls since the prior assessment. However, R29 had sustained a fall with major injury noted on 6/12/17, a fall with no injury on 7/8/17 and a fall with major injury on 8/20/17.						
	dated 9/7/17, indicated The CAA indicated quarter and her mo The CAA further incleft hip fracture from R29 had recent retidepartment was wo	re Area Assessment (CAA) ated R29 was at risk for falls. R29 had a history of falls last st recent fall was 8/20/17. dicated R29 had sustained a n the fall. The CAA indicated arn from hospital, therapy orking with R29 and safety ed in place. Staff were alert to or fall potential.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00668	B. WING		09/2	2/2017
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BROWNS VALLEY HEALTH CEN	NTFR	ERSON STR VALLEY, MI	EET SOUTH N 56219		
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES NUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
was over 9 was at rist Risk Assessments were 9/20/17, at 3:04 p.m., 3:23 p.m., identified Fat risk for falls due to care plan listed various included: use of a low resident did not reme assistance with transfation anticipate needs, in proper fit, reduced slip easy reach, no skid son bathroom door to a in bed, and safety bed alarms for resident at Review of the facility assistant registered) of directed staff to use 2 safety devices included door TABS and wand interventions were list On 9/19/17, at 11: 33 lying in her bed on he a low position, and obgrab bars in place and had a colored mat loo side of her bed and a was present on the lea white rectangular be attached to the left green.	essment dated 9/7/17, score of 24. The daresident whose score k for falls. No further Fallere provided by facility. ent care plan printed on last updated 8/21/17, at R29 had dementia, and was cognitive deficits. R29's us interventions which who bed, perimeter mattress, ember that she needed fer or ambulate and directed aspect shoes/footwear for p shoes, keep call light in strips in front of toilet, alarm alert entering, gripper socks d/chair alarms and floor mat that all times. form titled NAR (nursing Care Sheet, dated 9/20/17, 20 staff for transfers, and led alarm BR (bathroom) lerguard. No further fall the don the care sheet. a.m. R29 was observed er right side. Her bed was in observed to have bilateral daroncave mattress. She cated on the floor on the right a black pressure floor mat beft side of her bed. She had	2 830			

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STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00668	B. WING		09/2	2/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BROWN	S VALLEY HEALTH C	FNTFR	ERSON STR VALLEY, MI	EET SOUTH N 56219		
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	On 9/20/17, at 2:17 in bed with the head bed was in low pos in place and a cond She had a TABS all grab bar. The strint to her shirt with a machine shoulder. A black property in place on the left spadded mat was on her bed. On 9/21/17, at 5:28 on her back with eywas in low position. There was a black floor near the left sipadded mat on the bed. The TABS all left grab bar with a unit to under her back. Review of R29's Inc. Investigation Report revealed the following revealed the following the slipped while attemindicated gripper so bedtime, no alarms fall, and no injury not cause of fall was improper footwear.	p.m. R29 was observed lying of bed slightly elevated. The ition. Grab bars were observed ave mattress was on the bed. arm unit attached to the left g from the unit was attached to the left g from the unit was attached to the left of left	2 830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED	
		00668	B. WING		09/2	2/2017
	PROVIDER OR SUPPLIER S VALLEY HEALTH C	ENTER 114 JEFF		STATE, ZIP CODE EET SOUTH N 56219		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	-11/29/16, at 10:20 her bed. R29 was doose stool, stated stool, although she report listed R29 has shoes on her feet. Shad last toileted. A 12/5/16, identified the self transferring and monitor BM pattern bed so resident ablealarms applied. -12/4/16, at 2:07 p.r and found sitting or nightstand. R29 wa wrist" and rubbed hooked under her bethe floor under the lon R29's wrist. An 12/5/16, identified the R29 resident appear that fell under her boff of bed. Evaluati to number of falls. -1/24/17, at 6:50 p.r roommate and notion outside her bedisorientated, appear wheelchair alarm haresident and not so and a pad alarm plate IDT meeting note do root cause of fall was wheelchair while atthad removed TABS	p.m. found on the floor next to lisorientated, incontinent of she had been reaching for a pointed to her nightstand. The lid gripper socks on, and wore Staff were unaware when R29 in IDT meeting note dated he root cause of fall was R29 d loose stools. Nurse to move night stand closer to be to reach from bed, TABS m. staff heard a loud sound in the floor in front of her is disorientated, stated "my er wrist, no injury noted. Staff and retrieved a bracelet on bed. The bracelet was placed IDT meeting note dated he root cause of the fall was ared to attempt to get bracelet ed when lost balance and fell on sent to therapy in regards m. staff had been assisting bed R29 on the floor in her	2 830			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00668	B. WING		09/2	2/2017
NAME OF	PROVIDER OR SUPPLIER	<u>I</u>	DRESS, CITY, S	STATE, ZIP CODE	1 00/2	, 2011
BROWN	S VALLEY HEALTH C	ENTER 114 JEFF	ERSON STR VALLEY, MI	EET SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	- 2/6/17, at 6:30 p.r near the conference against a geri-chair wheelchair next to lalarm had been attaremoved clip, alarm noted. The report is transferred to a ger front of the confere removed from the confere not in the confere removed from the confere No IDT meeting not confere not in the conference of the conferen	n. found sitting on the floor e room, with her back leaning. R29 was disorientated, her, with brakes on. TABS ached to resident, resident in not sounding. No injury dentified R29 had self ii-chair which was stored in nece room. The geri-chair was common area and properly rence room with doors shut. It was were found. m. found on floor with her fall, in her bathroom. R29's hormal for her, and had fall hig. She had removed the which had been hooked on the ne report listed a secondary form floor, had not been R29 expressed some her upper torso and chest ray completed on 2/13/17, indings. Staff educated on the ry alarm, toileting plan. An ated 2/13/17, identified R29 illet and fell. TABS alarm was a door to alert staff of taking dendum dated 9/20/17, (during he care plan was not followed alarm had already been in dont address how to deal with	2 830			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING.			
		00668	B. WING		09/2	2/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BROWN	S VALLEY HEALTH C	FNTFR	ERSON STR VALLEY, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	had been attempting fell. The note indiction followed, the immess was the use of a TA to alert staff of any clinical record indiction wheelchair had been 1/24/17, 2/6/17, and had been placed on 1/24/17 fall. The not documentation of a disorientated, and of her right shoulder with top of her right claw swelling around the knee was also note with movement of the R29 reported, "I fel after the fall. The refor all transfers with portable x-ray was indicated a portable fracture of her distaincluded written stawhich noted R29 he approximately 6:30 visible bruises and time. The staff state rounds had been on was sleeping at the pain. A staff written indicated the staff of morning cares on 6 indicated during ca arm hurt and staff of and front of her right included written staff or the pain of the right included written staff of the right included written	inge 12 Ing to transfer self into bed and ated R29's care plan had been diate intervention put in place ABS alarm on the wheelchair self transfer. However, R29's ated the alarm on her en in place during R29's d 2/12/17 falls and a pad alarm in R29's wheelchair after R29's be lacked any further analysis of R29's fall. Induring a.m. cares R29 was complained of discomfort in with movement. A bruise on the ricle region was noted, with exite. A scrape below her right extension and denied any assistance export listed staff were to use 2 in a gait belt until after the completed. The report ex-ray done identified a fall right clavicle. The record attements from staff dated and been assisted to bed at p.m. on 6/11/17 and had no no complaints of pain at that ement indicated 5:00 a.m. completed on 6/12/17 and she at time and no complaints of statement, dated 6/13/17 member had assisted R29 with 6/12/17. The statement res, R29 had indicated her found bruises on her shoulder at leg. The record also attements from 6/13/17, which did had been unable to be put in	2 830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00668	B. WING		00/0	12/2017
					09/2	22/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BROWN	IS VALLEY HEALTH C	FNIFR	ERSON STR			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	low position a week personnel had been Maintenance had do bed needed to be do to the lowest position until the nestatement from ma 6/13/17 indicated happroximately 3 incoposition possible, of the bed and installed meeting note dated been noted to have pain in her right should be noted and she nobody had helped was revised to inclust that time. No docur investigation of the noted, no further arror function of the sabeen completed. - 7/8/17, at 8:55 a.r. side on the floor, in resident's bathroom unhooked her alarm assistance, remove and was in stocking TABS alarm pressure had in the resident's bathroom on injury, and care immediate interven a pressure pad in had self transfers. No further stocking transfers. No further stocking transfers.	a prior and maintenance in notified of the broken bed. etermined new parts for the ordered, and adjusted the bed on, and would remain in that it we part installed. The written intenance personnel dated in the had set the bed in the hes higher than the lowest ordered the needed parts for the date the parts on 6/13/17. An IDT 6/13/17, indicated R29 had bruising and complaints of boulder during morning cares. Staff had asked R29 what had stated she fell and her get up. R29's care plantaged.	2 830			

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00668	B. WING		09/22/2017	
NAME OF I	PROVIDER OR SUPPLIER	etdeet Ap	DDECC CITY O	STATE, ZIP CODE	•	
NAIVIE OF I	THO VIDEN ON SUFFLIEN					
BROWNS VALLEY HEALTH CENTER		ERSON STR VALLEY, MI				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 14	2 830			
	wheelchair after the facility having know removed/unhooked	rm had been placed on R29's e 1/24/17 fall. Despite the ledge R29 repeatedly alarms previously, analysis of ons and use of alarms had not				
	found R29 on the fl- walker in her room. indicated she was g "buff the floor." The been observed earl off herself. R29 de The report indicated out of resident sight take off the alarm of 8/21/17, R29 indicated left leg and hip area was unwilling to train that time, identified fracture of the left for degrees varus angual fragment. An IDT midentified staff noted TABS alarm earlier	a.m. staff heard a noise and oor outside her room, with her R29 was disorientated and going to close the door and report identified R29 had ier in the shift taking alarms nied discomfort at that time. It is staff were to place bed alarm than and reach, so she would not or turn the alarm off. On ted she had discomfort in her and an acute intertrochanteric emur associated with 90 ulation of the femoral shaft neeting note dated 8/22/17, it that R29 had removed her in the shift and was talking unsettled earlier in the shift.				
	The note indicated was to reapply the she could not remo indicated on 8/21/1 leg and hip pain, gutransfer. Further, the been transferred to left hip fracture. The plan had been follow R29's fall was docu R29's repeated rem	the immediate intervention TABS alarm and place where ve it herself. The note 7, R29 had complained of left larded leg and was unwilling to le note indicated R29 had the hospital for evaluation of a le note indicated R29's care wed. No further analysis of lamented. However, despite noval/unhook of alarms, no had been implemented prior to				

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R29's fall on 8/20/17.

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00668	B. WING		09/2	22/2017
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
BROWN	S VALLEY HEALTH C	FNIFR	ERSON STR VALLEY, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 15	2 830			
	Review of R29's pro 9/20/17, revealed th	ogress notes from 11/29/16 to ne following:				
	sitting next to bed, brakes not locked. feet, gripper socks	.m. R29 was found on floor, wheelchair in front of her, Denied pain. Was in stocking applied. Maintenance notified strips next to her bed. Hourly safety.				
	-11/29/16, at 10:29 p.m. R29 was found sitting on floor next to her bed. Was wearing gripper socks and shoes. Her wheelchair was behind her. Denied pain. R29 indicated she was reaching for stool, but pointed towards nightstand. Put back into bed, TABS alarm in place.					
	found R29 on the fl R29 indicated her w under bed and foun	m. staff heard loud sound, oor in front of her nightstand. wrist and rubbed it. Looked ad bracelet, retrieved and R29's wrist. No injury noted.				
	with safety interven	m. R29 identified as fall risk tions in place. Has had falls Il 12/4/16. Grab bars and used.				
	completed. R29 wa	,				
	-1/16/17, Discontinu Restorative AROM(motion)/Toileting pr					
	-1/24/17, at 11: 58 p	o.m. R29 was found on the				

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STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7t. Boilesiiva.			
		00668	B. WING		09/2	2/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BROWN	S VALLEY HEALTH C	FNTFR	ERSON STR VALLEY, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	floor outside the banoted. Placed a para fall identified alarm -2/6/17, at 7:23 p.m sitting on floor with Geri-chair with whe brakes on. R29 ha alarm and it was not Geri-chair removed properly stored in coshut. -2/12/17, at 10:56 a floor of bathroom. complained of chest Message left for pri -3/13/17, at 1:35 p. quarter. Last fall was R29 had severe con BIMS score of 5. Flast 3 months and a R29 has history of The follow up x-ray -3/20/17, at 4:31 p. recognized objects recognize place, tin -5/21/17, at 1:49 p. R29's safety device assessment indicat Does wander in whasking for help and transfer in and out using an alarm on bused in bed, wheeld	throom at 6:50 p.m. No injury id alarm on chair. Cause of was on chair and unhooked. I. R29 was found at 6:30 p.m. back leaning against elchair next to resident with dremoved the clip from the st sounding. No injury noted. I from common area and onference room with doors I.m. R29 was found sitting on R29 had self transferred. R29 st pain and mid area sharp. mary physician. Im. R29 had falls in last as 2/12/17. Note indicated gnitive impairment with a R29 has rolled out of bed in the aperimeter mattress is used. Chest pain from previous fall. indicated no fracture. Im. note indicated R29 and people, but did not	2 830			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00668	B. WING		09/2	22/2017	
NAME OF PRO	OVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
BROWNS V	ALLEY HEALTH C	FNTFR	ERSON STR VALLEY, M	EET SOUTH N 56219			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
-6 far in im La ha to in ca -6 so of cl sir kr as no or Tv tra -6 fra ph -6 w ph cl ph sa -6 ar As be N	alls this quarter, last terventions in place in pairment and disconnected fall from ad a perimeter may be about any any and a perimeter may be all and a perimeter may be all and bladded atterventions. No chare. 6/12/17, at 8:15 a. queezed right shout a pain. R29 had a avicle region, sweete. A scrape was nee. R29 stated saked if anyone helps. R29's primary proders were received wo staff assistance ansfer belt until Pformatter of distal rights and a perimeter since hysician was notificated avicle strap to use the strap to use th	a. At risk for falls, R29 had had st fall 3/28/17, and safety be. R29 has severe cognitive orientated to time and place. bed was 3/28/17, and R29 attress in place. No changes or assessment or nanges or updates to plan of m. R29 grabbed and ulder winced and complained bruise on top of her right alling was noted around the noted also below R29's right he fell when asked, and when ped her she shook her head onlysician was notified and and for a PPX (portable x-ray). The for R29 with all transfers and PX completed. The fell was for x-ray indicated the clavicle. R29's primary					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00668	B. WING		09/2	2/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BROWNS VALLEY HEALTH CENTER			ERSON STR VALLEY, MI	EET SOUTH N 56219		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	Continued From page 18		2 830			
	attempting to get ou Staff explained this -7/5/17, at 2:27 a.m wheelchair from 12	i. R29 was up in her :10 a.m. to 2:00 a.m. R29 had the north and south doors and				
	-7/5/17, at 3:16 p.m physician to discont follow up clavicle x-	n. new order from primary tinue the clavicle strap, to do a ray and for physical and by to evaluate and treat for				
	resident's bathroom side. R29 had remi- her TABS alarm. No pressure alarm was seat. Further, the no alarms do not prever resident whereabour	n. R29 was in another of doorway lying on her right oved her shoes and removed to injury noted. A TABS of placed in her wheelchair ote included "Remember, ent falls, they just alert staff to uts, so if not alarming, is not an not being followed, ortable."				
	activity tolerance, some difficulty. R29	.m. R29 had declined in trength, and transfers were 9 was unable to walk since ders received for therapy to				
		a.m. Chest of drawers was re plan was followed.				
		.m. active therapy services estorative program remained in				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						(3) DATE SURVEY COMPLETED	
		00668	B. WING		09/2	2/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
BROWN	S VALLEY HEALTH C	FNTFR	ERSON STR VALLEY, MI	EET SOUTH N 56219			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE	
2 830	-8/16/17, at 5:38 a.i from 1:00 a.m. to 3 R29 told the writer to syrup, but she did reliably and watched -8/19/17, at 7:15 p.i outside and her was off. One to one visit toileted8/20/17, at 12:00 at on her bed. R29 withen back to bed arringing and R29 information woodticks. Staff chowoodticks. Bed also activated. Call light -8/20/17, at 12:45 at coming from R29's outside of her room her room. R29 stated door and buff the flocentimeter bump or discomfort. Ice was back to bed with as belt. R29 was obsettime. Informed she and R29 continued Alarm moved out of -8/20/17, at 4:37 a.i were on and not with discomfort.	m. R29 was in her wheelchair :30 a.m. The note indicated that the girl needs cough not. R29 ambulated out to the TV for awhile. m. R29 was attempting to get inderguard alarm was going it completed and resident a.m. R29 was setting off alarm as assisted to the bathroom and alarms were activated. a.m. R29's bed alarm was cormed staff that she had becked R29 and found no arm and floor mat were was within reach. a.m. staff heard a noise room. She was on the floor and her walker was inside the sed she was going to shut the cor. R29 sustained a 2 in her head and denied as applied. R29 was assisted sistance of 2 staff and gait erved to unhook alarm at this a needed to keep the alarm on to play with alarm buttons.	2 830				
		m. R29 complained of left hip sitting in her wheelchair. R29					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00668	B. WING		09/	22/2017
	PROVIDER OR SUPPLIER S VALLEY HEALTH C	114 JFFF	DRESS, CITY, S	STATE, ZIP CODE EET SOUTH		
BIIOWI	5 VALLET HEALITTO	BROWNS	VALLEY, MI	N 56219		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 20	2 830			
		eft leg. R29's primary ed, and orders for x-ray were				
	2 hours and was ro was applied for con	m. R29 was repositioned every lled to support her left leg. Ice nfort. R29 showed signs of ing and guarded her left leg				
	-8/21/17, at 9:00 p.i	m. x-ray of pelvis and left hip.				
	fracture of left hip. notified. Orders for catheter, to keep re	n.m. x-ray results indicated R29's primary physician was foley indwelling urinary esident on bed rest, NPO (no dnight and to transfer for ing.				
	for left femur fractuorders received, inc	m. R29 returned from hospital re and left hip fracture. New cluding PT (physical therapy) nal therapy) to evaluate and				
		m. R29 had left hip pinned on tion 8/25/17. Hoyer lift for all				
	judgement and did	m. R29 exercised poor not use call lights. Low bed, d in place and activated. Call ch.				
	completed and 90 c reviewed including Safety indicated fall bed/chair/floor alarr	m. care conference was day assessments were R29's comprehensive report. ls, wanderguard, ms,bed low, anti-rollbacks. No ion of a comprehensive				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00668	B. WING		09/2	2/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BROWN	S VALLEY HEALTH C	FNIFR	ERSON STR	EET SOUTH N 56219		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 21	2 830			
	assessment of R29	's falls was documented.				
	impairment. R29's with recent hip frac	n. R29 had severe cognitive nealth status had changed ture and pinning. R29 had gy and poor appetite.				
	On 9/5/17, at 8:50 a last fall 8/20/17, fall interventions in plactransfers and she was at the second secon	m. review of progress notes. a.m. has had falls this quarter, risk noted, safety ce. Hoyer used for R29's vas unable to walk. R29 for falls. Staff noted fall risk				
	-9/6/17, at 1:35 p.m. care conference held and 90 day assessments reviewed including Resident Comprehensive Report. Fall, wanderguard, bed/chair/floor alarms, bed low, anti-rollbacks. No further documentation of R29's fall assessment was documented.					
		PT evaluation completed for active therapy services.				
	registered nurse (R					
	trying to climb out of the wheelchair with staff. R29 refused time. Acetaminopho given to the resider R29 was unable to	m. R29 was restless and of bed. R29 was assisted up to extensive assistance of 2 to go to the bathroom at that en 325 mg X 2 tablets were not for right hip and leg pain. rate pain, and her incision site R29 was given pudding for a				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00668	B. WING		09/2	2/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		-	
BROWN	S VALLEY HEALTH C	FNTFR		EET SOUTH			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	VALLEY, MI	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)	
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE	
2 830	Continued From pa	ge 22	2 830				
	devices currently in Note indicated to comeet her safety need R29 was not active strings/devices. R2 to meet her needs. active therapy to review comes in Note	29's plan of care was modified R29 was being seen by ces. Screen was to be sent to urrent safety in place and aide with					
	indicated the last tir attempted to take the	9/20/17, at 1:39 p.m. NA-A me she was aware R29 ne alarm off was several a a month or two ago."					
	utilized a TAB alarm R29 and she also h door. She stated R2 She indicated R29 indicated R29 had i	p.m. NA-D indicated staff in her bed and wheelchair for ad an alarm on her bathroom 29 did not use her call light. was at risk of falls. She removed her alarms in the ware of her doing it lately.					
	utilized a TAB alarn wheelchair which si shirt. She indicated her alarm in awhile added a pressure fl fracture. R29 utilize on the side near the seen her get out of						
	watched R29 for fa	B p.m. NA-C indicated staff lls. He indicated R29 utilized a cated he was aware R29 self					

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AND DUAN OF CORRECTION IN IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00668	B. WING		09/2	22/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BROWN	IS VALLEY HEALTH C	FNIFR	ERSON STR			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	transferred. He inditransfer at least one time he was aware last evening at appheard the floor alar he did not feel R29 herself. On 9/20/17, at 2:49 with RN-A and licer RN-A indicated LP1 assessments for the last fall risk assess 9/7/17, and she socianything over 9 ind of falls. RN-A state broke her clavicle a most recent fall. She made many changes staff needed to prove R29. RN-A indicate routinely in a weeklidentified as a intertime, interventions were made as need documented the more sident's chart. However, the fall so IDT meetings failed R29's risk for falls to trends/patterns to for causing the falls, an interventions. On 9/20/17, at 3:04 R29's clavicle fract staff to 2 assist with living) and the floor	icated R29 attempted to self ce a day, and the most recent of R29's self transfer was the roximately 7:00 p.m., when he m pad sound. NA-C indicated could remove the TAB alarm I p.m. during group interview used practical nurse (LPN)-A, N-A completed fall e facility. RN-A indicated her ment had been completed on ored 24, and a score of icated the resident was at risk and R29 had fallen in June and and fractured her hip with her he indicated the facility had ses to R29's care plan because vide much more assistance to ad the facility reviewed falls by therapy meeting which she disciplinary meeting. At that were reviewed and changes ded. RN-A indicated the facility eeting in a IDT note in each cene investigation forms and do to comprehensively assess to include but not limited to alls, factors that may be	2 830			

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AND DIAN OF CODDECTION INDESTRUCTION NUMBERS		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		00668	B. WING		09/2	2/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BROWN	S VALLEY HEALTH C	FNIFR	ERSON STR VALLEY, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	had severe cognitive hallucinations and is reliable historian re R29's clavicle fractives he felt R29 was right not and felt her cognitive and felt her cognitives aware R29 had alarm and continue indicated she felt R1 hour checks, and toileting patterns in were in R29's room roommates condition put in a formal programmed on 8/20/17, at 4:16 (DON) confirmed Right indicated her care princlude applying the she could not remo on 8/22/17. The DO have been updated During review of R2 with surveyor, the Dinconsistencies with the placement of the unable to explain the p.m. DON stated she revisions to the care felt that was the real She indicated she are related to placemer removed because in During follow up intindicated licensed she are she indicated licensed she are lated to placemer removed because in During follow up intindicated licensed she are she indicated licensed she are lated to placemer removed because in During follow up intindicated licensed she are lated to placemer removed because in During follow up intindicated licensed she are lated to placemer removed because in During follow up intindicated licensed she are lated to placemer removed because in During follow up intindicated licensed she are lated to placemer removed because in During follow up intindicated licensed she are lated to placemer removed because in During follow up intindicated licensed she are lated to placemer removed because in During follow up intindicated licensed she are lated to placemer removed because in During follow up intindicated licensed she are lated to placemer removed because in During follow up intindicated licensed she are lated to placemer removed because in During follow up intindicated licensed she are lated to placemer removed because in During follow up intindicated licensed she are lated to placemer removed because in During follow up intindicated licensed she are lated to placemer removed because in During follow up intindicated licensed she are lated to placemer removed because in During follow up intindicated l	re impairment, history of indicated she felt R29 was a lated to the incident when are was found. RN-A indicated ght on and sometimes she was nitive status was intermittent. If felt R29 could still tively. LPN-A indicated she da history of removing her do to remove her alarms. RN-A 29 would not be candidate for she had no consistency with the past. RN-A stated staff a lot, because of her on, but the facility had never gram for R29 safety checks. p.m. director of nursing 129's current care plan and plan should of been updated to be TABS alarm in a place where we it when this was discussed on the NAR care sheet. 29's electronic health record 20'N stated there were in the computer data related to be clip for the alarms and was be inconsistencies. At 4:29 the had been made aware of the plan made at that time, and alson for the inconsistencies. As sumed the intervention and of the clip for alarm was to was no longer effective.	2 830			
		no longer tried to remove her nat intervention was no longer				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		00668	B. WING		09/2	2/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
BROWN	S VALLEY HEALTH C	FNTFR		EET SOUTH			
	I	BROWNS	VALLEY, MI				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETE DATE	
2 830	Continued From pa	ge 25	2 830				
2 830	needed. She confirindicated she felt shalarm or self transfe aware of the self tra R29's medical reco On 9/21/17, at 5:31 sometimes restless had slept very well slept better last nigl out of the room dur the roommate woul R29. RN-B indicated try to self transfer sindicated she was a R29 continued to at fractured hip. She in R29 attempt to self week prior, when sliegs back into bed. and indicated R29 a what staff say to he RN-B indicated the attempted self transwhen a nursing staft transfer. RN-B indicated the attempted self transwhen a nursing staft ransfer. RN-B indicated her fracility had implement and stated R29's flof for a few months, blong it had been util aware R29 knew ho and that she had shalarm she	med R29 was restless, but ne had not tried to remove her er. DON stated she was not ansfer attempt documented in					
	herself every other indicated R29 was	day or every third day. RN-B confused at times, was difficult rstood and indicated that was					

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		(X1) PROVIDER/SUPPLIER/CLIA				X3) DATE SURVEY COMPLETED	
		00668	B. WING		09/2	2/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
BROWN	S VALLEY HEALTH C	FNTFR	ERSON STR VALLEY, MI	EET SOUTH N 56219			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 830	On 9/21/17, at 5:54 (TMA)-A indicated and indicated R29 had stated the long time, and the following time, and the	a.m. trained medication aide R29 utilized a TABS alarm always took it off. She been able to remove the clip of om wherever it was placed. 29 also had a pressure floor e alarms had been in place a loor pressure alarm on the d for R29 6 months or more. We also had a door alarm on ent staff also. TMA-A indicated and communicated in only a stated R29 sometimes tried to and she could get herself onto l. a.m. NA-G indicated R29 was floor pressure alarm, which prior to the fractured hip. She not aware R29 had attempted the had her hip fracture. a.m. NA-H stated R29 was as aware R29 had attempted the before, when she had a girl running around and and find her. He stated he had the alarm had not the wher attempting to get up the most recent self transfer.	2 830				

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AND DUAN OF CODDECTION IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00668	B. WING		09/2	2/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BROWN	S VALLEY HEALTH C	FNTFR	VALLEY, M	EET SOUTH N 56219		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	on Mondays the factor meetings and falls and documentation LPN-A confirmed sompletion of the fastated the facility of assessments for accreturns and change she had assisted wincident on 6/12/17 fracture. She indictinterviewed R29 and questions at that tirk was initiated, a claval assistance of 2 state contained. She state 7/8/17, and stated a in R29's wheelchair R29 was confused delusional earlier of indicated she though was initiated when hospital. After revied dated 8/20/17, at 12 confirmed the preseprior to the fall on 8 on 9/21/17, at 7:01 a little confused, and for as long as she with the pressure floor in since she broke he current NAR care stabs alarm or specitive alarm. NA-I indicated prior to the transfer at least one confirmed the president of the stabs alarm or specitive alarm. NA-I indicated prior to the transfer at least one confirmed the president of the stabs alarm or specitive alarm. NA-I indicated prior to the transfer at least one confirmed the president of the stabs alarm or specitive alarm. NA-I indicated prior to the transfer at least one confirmed the president of the stable president of the sta	cility held therapy/IDT were reviewed at the meetings of the meetings were done. he was responsible for all assessments and LPN-A completed comprehensive fall dmissions, annually, hospital e of conditions. She indicated ith the investigation of R29's , which resulted in the clavicle ated another nurse had d R29 was able to answer ne. LPN-P indicated therapy ricle brace was utilized and if for transfers were red R29 had another fall on a pressure alarm was placed at times and verified R29 was in the shift of 8/20/17. LPN-A ght the pressure floor alarm R29 returned from the w of R29's progress note 2:30 a.m. with surveyor, she sure floor alarm was in place /20/17. a.m. NA-I indicated R29 was ad had a TABS alarm in place worked at facility and thought nat had been implemented in hip. She confirmed the heet did not include use of the fic directions on how to place cated she had not witnessed ince she broke her hip. She at, R29 would attempt self	2 830			

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Minnesota Department of Health STATE FORM

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00668	B. WING		09/2	2/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BROWN	S VALLEY HEALTH C	FNTFR	ERSON STR VALLEY, MI	EET SOUTH N 56219		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	printed NAR care s confirmed R29's cu 9/20/17. She indica both the previous e had talked with R29 bruises on her shoutold her she "fell", a no one assisted her up. She indicated s bruising on R29 wa On 9/21/17, at 7:37 practiced was to do meetings for specific report. She indicated incidents reviewed titled BVHC Therap documentation of a 6/12/17 fall had not R29 had been reviewed titled BVHC Therap documentation of a 6/12/17 fall had not R29 had been reviewed titled BVHC Therap documentation of a 6/12/17 fall had not R29 had been reviewed titled BVHC Therap documentation of a 6/12/17 fall had not R29 had been reviewed titled BVHC Therap documentation of the status and medical cause of R29's 7/8/was found on the flounted earlier she was confused. DON intervention implementation implementation the TABS alaremove herself. She interventions were in DON stated the usucharge nurse to constaff involved were statements of the indetermined if the indetermined in the index i	heet dated 9/20/17 and rrent care plan, printed ted she had made changes to vening. RN-A confirmed she after she was noted to have alder and indicated R29 had nd had not asked for help and rand it was hard for her to get he felt the cause of the s from the reported fall. a.m. DON stated her usual cument minutes of the IDT ic residents in the incident d she maintained a log of at the meetings, on a form y meeting and confirmed review of R29 after the been done and confirmed review of R29 after the been done and confirmed status was found to be the 17 fall. She confirmed R29 por on 8/20/17 after staff had as removing her alarms and a indicated the immediate ented at that time was to arm in a place she could not be verified no further mplemented at that time. The pual facility practice was for the mplete an incident report and to complete witness acident. The DON was notified, cident was a reportable event.	2 830			
		e for falls was for LPN-A to rehensive fall assessments.				

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STATEMENT OF DEFICIENCIES (X1)

AND DUAN OF CODDECTION INTERPRETATION NUMBER.					DATE SURVEY COMPLETED	
			A. BOILDING.		33 2272	
		00668	B. WING		09/2	2/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BROWN	S VALLEY HEALTH C	ENTER	ERSON STR VALLEY, M	EET SOUTH N 56219		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 830	and the MDS coord assessments and condicated a charge incident report, utilize to gather information. IDT would review the She indicated the II information sooner R29's current care. She confirmed R29 herself on 7/8/17 and On 9/21/17, at 1:54 comprehensive fall significant change. It indicated she had really fall assessments we provide any further assessments comprehensive fall assessments comprehensive fall assessments we provide any further assessments comprehensive fall assessments comprehensive fall assessments we provide any further assessments comprehensive fall assessments comprehensive fall assessments comprehensive fall assessments we provide any further assessments comprehensive fall assessments comprehensive for indicated distally and fall assessments we have also for indicated distally and fall assessments we have a session of the classification of the cla	linator reviewed the completed the care plans. She nurse would complete the zed the fall investigation form on for the report and then the ne fall at the routine meetings. DT would review the if needed. DON confirmed plan and NAR care sheets. In had removed the alarms and 8/20/17. P.m. RN-A confirmed the assessment done with the MDS CAA on 9/7/17. She eviewed R29's comprehensive ith DON and was unable to comprehensive fall pleted for R29. Dhysician's progress notes 7 revealed the following: Try talkative but she denied ach pain, no back pain, no lilen today, but was not hurt. nondisplaced fracture of the twicle and that is ok. Take the care plans. She was tired. The complete the care plans. She investigation form and the care plans in the care plans. The care plans is the care plans in the care plans is the care plans in the care plans is the care plans. She was tired. The care plans is the care plans. She investigation form and the care plans is the care plans in the care plans is the care plans. She investigation form and the care plans is the care plans. She investigation form and the care plans is the	2 830			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND DUAN OF CODDECTION DENTIFICATION NUMBER.					TE SURVEY MPLETED	
		00668	B. WING		09/2	2/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BROWN	S VALLEY HEALTH C	ENTER	ERSON STR VALLEY, M	EET SOUTH N 56219		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 30	2 830			
	from R29's hospital revealed the followi	stay from 8/22/17, to 8/25/17 ng:				
	physical dated 8/22 systems unobtainal dementia. Due to t benefits and alterna	thcare System history and 1/17; indicated review of ole due to the patient's he patient's dementia, risks, atives were discussed but t is truly understanding ge.				
	-Prairie Lakes Healthcare System discharge summary dated 8/25/17, She does have chronic dementia, so unfortunately is limited on what she will answer when we ask he questions.					
	Health Services of reviewed and amer guidelines and procidentify, assess, treincidents that put the The policy directed root cause(s) of the to prevent reoccurrent patterns. A fall risk completed upon ad significant change of triggered, on a 90 cany time a restraint possible, within 48-	ry policy titled St. Francis Morris Accident/Incident inded on 4/16/15 identified redures that adequately at and prevent accidents and he resident at risk for injury. The IDT team to determine the e incident, the best approaches ence and identify trends and assessment would be mission, hospital returns, of condition, if falls are lay review, annual review and was applied. As soon as 72 hours the Interdisciplinary				
	team would comple accident/incident fo probable causes of further recommend and causes have be interventions that we nursing and or intervevaluated for effect	te the care center llow up form to further assess the incident and make any ations. Once the assessment				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND DUAN OF CODDECTION IDENTIFICATION NUMBER.			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
712 . 271	0. 0020		A. BUILDING:			
		00668	B. WING		09/2	2/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BROWN	S VALLEY HEALTH C	ENTER	ERSON STR VALLEY, M	EET SOUTH N 56219		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	follow up section or necessary this woul approximately a we assessment was corequired sooner that documented on the assurance team identified areas. The immediate jeony was removed on 9/2 comprehensively as implemented effect the facility fall policibe completed after trends and revise the Intervention change Celexa put on hold, hourly checks between tracking log for alar toileting plan was ascheduled toileting non compliance removerity of G, isolation occurred to R29. SUGGESTED MET director of nurses (I training to nursing sere-assessment after fall. An audit could lappropriate assessimplemented to ensemble committee.	an be documented on the on the form. If follow up was all be done by the IDT in seek from the date the team completed. If follow up is an a week, this would be a form as well. If the quality entifies significant causes or will be taken to correct the pardy that began on 6/12/17, f22/17, when the facility essessed R29 for falls, give interventions and revised ites to include a fall analysis to 2 or more falls to determine the care plan as needed. The est and a fall analysis to 2 or more falls to determine the care plan as needed. The end of the night hours. The mained at the lower scope and the during the night hours. The mained at the lower scope and the determine the care in the importance of the resident has experienced a seed of the importance of the resident safety. The corted to the quality assurance of the corted to the quality assurance of the corted to the quality assurance.	2 830			

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AND DUAN OF CODDECTION INTERPRETATION NUMBER.					B) DATE SURVEY COMPLETED	
		00668	B. WING		09/2	2/2017
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BROWN	S VALLEY HEALTH C	FNIFR	ERSON STR VALLEY, M	EET SOUTH N 56219		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 32	2 830			
	(21) days.					
21695	MN Rule 4658.1415 Housekeeping, Ope	5 Subp. 4 Plant eration, & Maintenance	21695			10/27/17
	provide housekeep necessary to mainta comfortable interior	eping. A nursing home must ing and maintenance services ain a clean, orderly, and , including walls, floors, ixtures, equipment, lighting,				
	by: Based on observati failed to ensure a cl was maintained for	ent is not met as evidenced on and interview the facility lean and sanitary environment 2 of 4 resident rooms verflowing garbage's.		Corrected		
	Findings Include:					
	residents R10 and I garbage pail overflo	2 a.m. a shared bathroom for R42, was observed to have a bwing with soiled incontinent of urine was also observed to om.				
	indicated the facility removing the garba they were full. NA-E	was responsible for removing				
	indicated resident re which included rem	3 p.m. housekeeping (H)-A coms were cleaned every day, oving garbage in the cated housekeeping staff were				

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AND DI AN OF CODDECTION IDENTIFICATION NUMBED:					(X3) DATE SURVEY COMPLETED	
		00668	B. WING		09/2	2/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BROWN	S VALLEY HEALTH C	FNTFR	ERSON STR VALLEY, MI	EET SOUTH N 56219		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21695	present in the facility only during day time housekeeping were NA's were responsionand remove the gard H-A further indicate early morning hours R10's and R42's shoverflowing with so indicated in the pasher shared bathroom overflowing with so indicated she had at the soiled products staff know if the gard before or after hous R42's quarterly Min 9/16/17, identified FOn 9/21/17, at 1:25 shared bathroom goverflowing with so stated she used to from the bathroom of the pile, however them up and was done of them up and was done of the pile, however them up and was done of the	ry Monday through Friday and e hours. H-A indicated when e not present in the facility, ble to collect soiled garbage rbage from resident rooms. d when she would arrive in the s, she would routinely find ared bathroom garbage eled incontinent products. H-A at R42 had reported to her that im garbage was routinely eled briefs. H-A further encouraged R42 to not pick up from the floor and to let facility rbage required changing sekeeping arrived. Imum Data Set, dated R42 had intact cognition. p.m. R42 indicated her arbage with R10 was routinely eled incontinent products. R42 pick up the soiled products up floor when they would fall off is she had been told not to pick irected to notify nursing staff. It spoken with a nurse, nurses ties, as recently as a few	21695			

PRINTED: 10/24/2017 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00668 09/22/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 114 JEFFERSON STREET SOUTH **BROWNS VALLEY HEALTH CENTER BROWNS VALLEY, MN 56219** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21695 Continued From page 34 21695 director (ED) indicated to his understanding if there were soiled incontinent products in residents rooms, it was the facility NA's who were responsible to remove the soiled garbage's when housekeeping staff were not in the facility. ED stated this would need to be on the evening and night shifts. ED further stated housekeeping would empty resident garbage's once a day and only more if requested by staff or residents. On 9/21/17, NA-K stated her usual shift to work was the evening shift and her usual process would be to check residents garbage's at the end of the shift, prior to residents going to bed. NA-K further indicated she would often not check R10 and R42's shared bathrooms, as both residents were independent with activities of daily living. On 9/21/47, at 3:51 p.m. NA-C indicated he worked all shifts and he would not routinely check garbage's on the south end of the building, which included R10 and R42's rooms and bathroom. NA-C indicated he would remove any soiled garbage's after he assisted residents with cares. however; residents who were independent with cares would not have their garbage's checked and changed at the end of the shift.

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bathroom.

garbage.

On 9/22/17, at 1:40 p.m. the director of nursing (DON) stated she would expect staff to clean up all residents rooms at the end of the shift to ensure the removal of soiled incontinent products.

this would include R10 and R42's shared

On 9/22/17, at 1:41 p.m. the social service designee/activity director indicated she was unaware R42 had concerns with her bathroom

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' ' ' ' '			E SURVEY MPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING:		COMP	LETED
		00668	B. WING		09/2	2/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BBOWN!	S VALLEY HEALTH C	ENTER 114 JEFF	ERSON STR	EET SOUTH		
BROWN	5 VALLET HEALING	BROWNS	VALLEY, M	N 56219		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21695	Continued From pa	ge 35	21695			
21000	On 9/22/17, at 2:30 coordinator indicate been told not to ent garbage's if the res further indicated the in place to remove from resident room cares, that included An undated facility Policy, revealed it wupon receiving a costeps would be take	p.m. the admissions ed facility nursing staff had er residents rooms to remove idents were sleeping. She ere was not a current process soiled incontinent products s which were independent in I R10 and R42. policy titled, Odor Elimination was the policy of the facility omplaint regarding orders, en to eliminate the odors. The ess maintaining an odor free				
	administrator or des revise policies on re resident's environm odors and educate audit could be deve environment remain could be reported to committee.	THOD OF CORRECTION: The signee could develop and/or emoval of trash from the lent timely to prevent foul staff on those policies. An eloped to ensure the los odor free. The results of the quality assurance				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805			10/27/17
	residents have the courtesy and respe	us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a				

PRINTED: 10/24/2017 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00668 09/22/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 114 JEFFERSON STREET SOUTH **BROWNS VALLEY HEALTH CENTER BROWNS VALLEY, MN 56219** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21805 Continued From page 36 21805 This MN Requirement is not met as evidenced by: Based on observation, interview and document Corrected review the facility failed to ensure a dignified dining experience for 3 of 3 residents (R4, R5, R29) who required assistance with eating during the supper meal on 9/18/17 in the dining room. Findings include: On 9/18/17, at 5:04 p.m. R4 was seated in a black and purple tilt in space (adjustable reclining) wheelchair positioned at the table with her meal in front of her. R29 was to the left of R4. seated in her wheelchair at the table with her meal in front of her. To the left of R29 was an empty chair and then R5 was seated in a black tilt in space wheelchair, reclined at a 45 degree angle. R5 had her meal in front of her, but her eyes were closed and she was breathing through her mouth. Next to R5 was nursing assistant (NA)-I. NA-I was seated in a chair, leaning her elbow on the table as she fed R4 spoonfuls of food, not talking with any of the residents. At 5:11 p.m. NA-I remained seated at the table with R4, R29 and R5. NA-I was leaned over the table on her elbows, leaning to the right side, and offered spoonfuls of food to R4. She did not talk,

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during the meal.

or engage R4 in conversation while she assisted her to eat, and did not talk or engage R29 or R5

At 5:19 p.m., R29 coughed, NA-I stood up and walked over to R29 and offered her a glass of water. NA-I sat back down next to R4, resumed offering bites of food to R4. NA-I did not talk to R4

and did not engage her in conversation.

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AND DUAN OF CODDECTION IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00668	B. WING		09/2	2/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BROWN	S VALLEY HEALTH C	FNTFR	ERSON STR VALLEY, M	EET SOUTH N 56219		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21805	At 5:22 p.m. NA-B at table and sat next tonce. R5 did not op NA-B rubbing the towheelchair remained NA-B did not attem an upright position NA-B to wake R5. Noffered a bite of food At 5:33 p.m., NA-I rube table with her eR4. R29 continued food and R5 remained wheelchair at a 45 NA-I and NA-B did R29 in conversation sat down at the table without atternourage her to eat the eggs to the back of NA-I did not talk to eyes. NA-I and NA-discussed their indicates at home with the schedule at home with the continued to a while talking with Na-I continued to a while ta	approached the dining room on R5 and called her name been her eyes or respond to op of her right leg. R5's and tilted at a 45 degree angle, pt to adjust R5's wheelchair to and no further attempts from NA-B then turned to R29 and od. The mained seated, leaning on allows, feeding bites of food to to independently take bites of ned seated in tilt in space degree angle with eyes closed. The not talk or engage R4, R5, The not talk or engage R4, R5, The between R29 and R5. The mained seated at a 45 degree with eyes closed and mouth a spoonful of eggs into R5's anpting to wake her or at. NA-I used spoon to push k of R5 mouth to get a NA-I repeated pushing the her mouth until R5 swallowed. R5, and R5 did not open her ref talked with eath other, and vidual hours of work schedule. The NA-F continued to discuss as NA-I discussed her sleep with NA-F, and discussed me with NA-F. No No NA-F, and sobserved. Ssist R4 with bites of food	21805			

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00668	B. WING	09/22/2017	
PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED	

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

114 JEFFERSON STREET SOUTH

BROWN	S VALLEY HEALTH CENTER	ERSON STR VALLEY, M	EET SOUTH N 56219	
(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
21805	Continued From page 38	21805		
	the table with NA-I and NA-F. NA-F and NA-I continue to carry on a personal conversation between themselves, no attempts to engage the residents in conversation were observed.			
	At 6:02 p.m. R4 and R29 were assisted to leave the dining room.			
	On 9/18/17, at 7:45 p.m. NA-F confirmed she had been seated next to R5 during the supper meal. NA-F stated she felt R4, R5 and R29 kept to themselves at meals and confirmed she and NA-I continued in personal conversation with each other throughout the supper meal.			
	On 9/21/17, at 2:46 p.m. NA-I confirmed she had assisted R4, R29 and R5 with the supper meal on 9/18/17. She confirmed she had a personal conversation throughout the entire supper meal with NA-F and had not engaged the residents in conversation. She indicated she was aware this was not a dignified experience for R4, R5 or R29. NA-I confirmed, staff had received reminders in the past to limit personal conversations while assisting residents with their meals.			
	On 9/21/2017, at 2:56 p.m. director of nursing (DON) confirmed staff not engaging with residents during meal times was not acceptable practice. She indicated facility staff had been educated on assisting with meals and dignity in the past.			
	Review of the undated policy titled Browns Valley Health Center Dignity Policy ,indicated each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality.			
	SUGGESTED METHOD OF CORRECTION: The			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	T OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DE CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DE CONSTRUCTION			(X3) DATE COMP	SURVEY PLETED	
			A. BUILDING:			
		00668	B. WING		09/2	22/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BROWN	S VALLEY HEALTH C	ENTER	ERSON STR VALLEY, M	EET SOUTH N 56219		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21805 21980	director of nurses (training to nursing s providing a dignified residents. An audit staff are conducting with residents durin assistance. The re quality assurance of TIME PERIOD FOR (21) days. MN St. Statute 626	DON) could provide inservice staff on the importance of d dining experience to all could be developed to ensure g appropriate conversations ag meal times while providing sults could be reported to the committee. R CORRECTION: Twenty-one	21805			10/27/17
	Subd. 3. Timing of reporter who has revulnerable adult is lor who has knowled has sustained a phreasonably explained information to the condividual is a vulnerable the individual is a vulnerable the individual is additionally and the individual is additionally and the individual was another facility and believe the vulnerable previous facility; or (2) the reporter knowled that the individual is in section 626.5572 (b) A person not provisions of this sas described above	Inerable Adults of report. (a) A mandated eason to believe that a being or has been maltreated, dge that a vulnerable adult ysical injury which is not ed shall immediately report the formon entry point. If an erable adult solely because mitted to a facility, a mandated ired to report suspected endividual that occurred prior is: as admitted to the facility from the reporter has reason to be adult was maltreated in the enows or has reason to believe a vulnerable adult as defined 2, subdivision 21, clause (4). required to report under the ection may voluntarily report				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00668	B. WING		09/2	2/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BROWN	S VALLEY HEALTH C	ENTER	ERSON STR VALLEY, M	EET SOUTH N 56219		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21980	knows or has reason been made to the commander of the com	d maltreatment, if the reporter on to know that a report has common entry point. It is section shall preclude a reporting to a law enforcement reporter who knows or has not an error under section on 17, paragraph (c), clause make a report under this reporter or a facility, at any an investigation by a lead ne or should determine that was not neglect according to rection 626.5572, subdivision clause (5), the reporter or et to the common entry point or agency information explaining that the criteria under section on 17, paragraph (c), clause ney shall consider this naking an initial disposition of bedivision 9c. The porter of the service of the common entry point or agency information explaining the criteria under section on 17, paragraph (c), clause ney shall consider this naking an initial disposition of bedivision 9c.	21980	Corrected		
	where fall intervent facility failed to repo within 2 hours when	a fractured hip following a fall ions were not in place, and the ort potential neglect of care a aware of the fracture. In failed to implement policy for				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00668	B. WING		09/2	2/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BROWN	S VALLEY HEALTH C	ENTER	ERSON STR VALLEY, M	EET SOUTH N 56219		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21980	Continued From pa	ge 41	21980			
		rough investigation for 1 of 1 ewed with a injury of unknown bodily injury.				
	Findings Include:					
	signed 9/5/17, iden included dementia	gned Physician Order Sheet, tified diagnoses which with behavioral disturbance, pulmonary disease and pression.				
	6/6/17, identified Rincluded dementia, The MDS listed R2 impairment, and rewith dressing, hygic	imum Data Set (MDS) dated 29 had diagnoses which osteoporosis and depression. 9 had severe cognitive quired extensive assistance ene, toileting, transfers and r, the MDS identified R29 had r assessment.				
	identified R29 had required extensive hygiene, eating and	nange MDS dated 8/31/17, severe cognitive impairment, assistance with dressing, d locomotion, total assistance ting and did not walk.				
	3:04 p.m. last upda registered nurse (R potential for abuse. R29 was at risk for cognitive deficits ar activities of daily liv further indicated R2 needed assistance and instructed staff	plan printed on 9/20/17, at ted 8/21/17, at 3:23 p.m. by N)-A identified R29 had a The care plan also indicated falls or injury related to de required assistance with ing (ADL)s. The care plan 29 did not remember that she with transfer or ambulation, to anticipate her needs.				
		cident Details/Fall Scene rt from 6/12/17, revealed the				

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AND DUAN OF CODDECTION INTERCATION NUMBER.				(X3) DATE COMP	SURVEY LETED	
			B WING			
		00668	b. Willia		09/2	2/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BROWN	S VALLEY HEALTH C	ENTER 114 JEFFI	ERSON STR	EET SOUTH		
Bilowit	O VALLET HEALING	BROWNS	VALLEY, MI	N 56219		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21980	Continued From pa	ge 42	21980			
	following:					
	disorientated, and of her right shoulder with portable x-ray was indicated a portable fracture of her distaincluded written state which noted R29 has approximately 6:30 visible bruises and time. The staff state rounds had been cowas sleeping at that pain. A staff written indicated during car arm hurt and staff frand front of her righincluded written staindicated R29's become and from the position and been maintenance had ded needed to be on to the lowest position until the nestatement from main 6/13/17, indicated indicated had approximately 3 indicated y approximately 3 indicated y approximately 3 indicated y and front of her righincluded written staindicated R29's become was sleeping at the pain.	m. during a.m. cares R29 was complained of discomfort in with movement. A bruise on the icle region was noted, with a site. A scrape below her right d. R29 winced with discomfort he area. The report indicated and denied any assistance control isted staff were to use 2 and a gait belt until after the completed. The report ex-ray done identified a all right clavicle. The record tements from staff dated and been assisted to bed at p.m. on 6/11/17, and had no no complaints of pain at that ement indicated 5:00 a.m. completed on 6/12/17, and she at time and no complaints of statement dated 6/13/17, nember had assisted R29 with widely 12/17. The statement res, R29 had indicated her ound bruises on her shoulder and leg. The record also tements from 6/13/17, which is had been unable to be put in a prior and maintenance in notified of the broken bed. The tetral etc. The witten intenance personnel dated and would remain in that the part installed. The written intenance personnel dated are had set the bed in the higher than the lowest redered the needed parts for				

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l l	(X3) DATE SURVEY COMPLETED	
00668 B. WING 09/22/20	2017	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
BROWNS VALLEY HEALTH CENTER 114 JEFFERSON STREET SOUTH BROWNS VALLEY, MN 56219		
	(X5) COMPLETE DATE	
the bed and installed the parts on 6/13/17. An IDT meeting note dated 6/13/17, indicated R29 had been noted to have bruising and complaints of pain in her right shoulder during morning cares. The note indicated staff had asked R29 what happened and she had stated she fell and nobody had helped her get up. R29's care plan was revised to include 2 assist for transfers at that time. No documentation of further investigation of the cause of R29's injury was noted, no further analysis of the effectiveness/use or function of the safety devices in place had been completed. Review of R29's progress notes revealed the following: -6/12/17, at 8:15 a.m. R29 grabbed and squeezed right shoulder winced and complained of pain. R29 had a bruise on top of her right clavicle region, swelling was noted around the site. A scrape was noted also below R 29's right knee. R29 stated she fell when asked, and when asked if anyone helped her she shook her head no. R29's primary physician was notified and orders were received for a PPX (portable x-ray). Two staff assistance for R29 with all transfers and transfer belt until PPX completed. Review of submission to Office of Health Facility Complaints (OHFC) identified the report had been submitted on 6/13/17, at 1:07 p.m. Review of R29's investigation summary of the 6/12/17, incident revealed on 6/12/17, during a.m. cares NAR (nursing assistant registered) staff		

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STATEMENT OF DEFICIENCI AND PLAN OF CORRECTION	ES		ER/SUPPLIER/CLIA	` '	E CONSTRUCTION		E SURVEY PLETED
				A. BOILDING.			
		0066	8	B. WING		09/	22/2017
NAME OF PROVIDER OR SU	PPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BROWNS VALLEY HEA	LTH C	ENTER		ERSON STR VALLEY, M	EET SOUTH N 56219		
PREFIX (EACH DEF	ICIENC)		EFICIENCIES ECEDED BY FULL NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
shoulder are the top of the R29 stated she did not a assisted her, up. An x-ray fracture of that the time of Review of R2 Investigation following: -8/20/17, at 1 found R29 or walker in her indicated she "buff the floobeen observe off herself. Facture of the asylution was unwilling that time, ide fracture of the degrees varual fragment. An identified sta TABS alarm delusional ar The note ind was to reapp she could no indicated on leg and hip p	2:45 a the fl larm of a la	plained of proted a bruclavicle reg, and then vertile at 7:5 at right clavicent was followed at 8/20/17, respectively. The series of the serie	ils/Fall Scene evealed the evealed and her room, with her lisorientated and se the door and hiffed R29 had hift taking alarms infort at that time. It to place bed alarm of the place bed alarm of the area and event of the area and event of the area and event of the event of				

Minnesota Department of Health

STATE FORM 6899 NJ3911 If continuation sheet 45 of 49

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

00668 B. WING 09/22/2	/2017
09/22/2	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
BROWNS VALLEY HEALTH CENTER 114 JEFFERSON STREET SOUTH BROWNS VALLEY, MN 56219	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
been transferred to the hospital for evaluation of a left hip fracture. The note indicated R29's care plan had been followed. No further analysis of R29's fall was documented. However, despite R29's repeated removal/unhook of alarms, no other interventions had been implemented prior to R29's fall on 8/20/17. Review of R29's progress notes revealed the following: -8/20/17, at 12:45 a.m. staff heard a noise coming from R29's room. She was on the floor outside of her room and her walker was inside her room. R29 stated she was going to shut the door and buff the floor. R29 sustained a 2 centimeter bump on her head and denied discomfort. Ice was applied. R29 was assisted back to bed with assistance of 2 staff and gait belt. R29 was observed to unhook alarm at this time. Informed she needed to keep the alarm on and R29 continued to play with alarm buttons. Alarm moved out of reach of R29. -8/21/17, at 8:30 a.m. R29 complained of left hip pain when she was sitting in her wheelchair. R29 was guarding her left leg. R29's primary physician was notified, and orders for x-ray were received. -8/21/17, at 10:00 p.m. x-ray results indicated fracture of left hip. R29's primary physician was notified, orders for foley catheter, to keep resident on bed rest, NPO (no oral intake) after midnight and to transfer for surgery in the morning. Review of submission to OHFC identified the report had been submitted on 8/22/17, at 8:55	

6899

Minnesota Department of Health

PLETED
22/2017
(X5) COMPLETE DATE

Minnesota Department of Health

STATE FORM 6899 NJ3911 If continuation sheet 47 of 49

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00668	B. WING		09/2	22/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BROWN	S VALLEY HEALTH C	FNIFR	ERSON STR VALLEY, M	EET SOUTH N 56219		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21980	cognitive impairment hallucinations. She reliable historian rel R29's clavicle fractushe felt R29 was rignot and felt her cog RN-A indicated she communicate effections. On 9/21/17, at 7:16 talked with R29 after bruises on her shoutold her she "fell", ano one assisted her up. She indicated shousing on R29 was the facility policy to Services of Morris Maltreatment Reporeviewed/amended center must report any suspected maltinjuries of unknown later than 2 hours if SUGGESTED MET director of nurses (It training to nursing stimely reporting to the injury, and implement prohibition policy. And implement the required abuse prohibition policy. And implement abuse prohibition policy.	int, and history of indicated she felt R29 was a lated to the incident when are was found. RN-A indicated sht on and sometimes she was nitive status was intermittent. felt R29 could still tively. a.m. RN-A confirmed she had are she was noted to have alder and indicated R29 had not asked for help and are and it was hard for her to get the felt the cause of the strom the reported fall. Itled, St Francis Health Skilled Nursing Facility ring Guidelines, 11/18/16, included each care to the state agency (OHFC) treatment, which included source immediately, but not result in serious bodily injury. CHOD OF CORRECTION: The DON) could provide inservice staff on the requirement of the State agency of a major entation of the facility's abuse an audit could be developed to a components of the facility's olicy is consistently results could be reported to				
	TIME PERIOD FOR	R CORRECTION: Fourteen				

6899

PRINTED: 10/24/2017 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _____ B. WING _ 00668 09/22/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 114 JEFFERSON STREET SOUTH **BROWNS VALLEY HEALTH CENTER BROWNS VALLEY, MN 56219** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21980 21980 Continued From page 48 (14)- days.

Minnesota Department of Health

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PRINTED: 10/17/2017 FORM APPROVED OMB NO. 0938-0391

			1		1
		245564	B. WING		09/19/2017
	PROVIDER OR SUPPLIER S VALLEY HEALTH C	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 114 JEFFERSON STREET SOUTH BROWNS VALLEY, MN 56219	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
K 000	INITIAL COMMEN	тѕ	K 0	00	
3	FIRE SAFETY				
	ALLEGATION OF ODEPARTMENT'S A SIGNATURE AT THE	COC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE WILL BE USED AS F COMPLIANCE.			
	ON-SITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT OMPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOU VERIFICATION.			
	Minnesota Departn Fire Marshal Division Browns Valley Heat compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National (NFPA) Standard 1 Chapter 19 Existing	Survey was conducted by the nent of Public Safety, State on. At the time of this survey, Ith Center was found not in e requirements for participation aid at 42 CFR, Subpart ety from Fire, and the 2012 Fire Protection Association 01, Life Safety Code (LSC), g Health Care and the 2012 Health Care Facilities Code.			
	DEFICIENCIES (K	R THE FIRE SAFETY -TAGS) TO: spections			
	State Fire Marshal	Division DER/SUPPLIER REPRESENTATIVE'S SIG		TITLE	(X6) DATE

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.

If continuation sheet Page 1 of 10

10/11/2017

Electronically Signed

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION G 01 - MAIN BUILDING 01		MPLETED
		245564	B, WING			/19/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 114 JEFFERSON STREET SOUTH BROWNS VALLEY, MN 56219		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 000	DEFICIENCY MU FOLLOWING INF 1. A description of to correct the defice 2. The actual, or p 3. The name and/responsible for co	Suite 145 01-5145, OR state.mn.us an@state.mn.us ORRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION: what has been, or will be, done	K 000			
	with a partial base constructed at 2 d building was considetermined to be a 2001 an addition of determined to be a sprotected by a function that the original building same type construction and the surveyed as one building the surveyed as one build	-				
	The building is full	v sprinkler protected and the				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01		E SURVEY PLETED
		245564	B. WING		09/	19/2017
	PROVIDER OR SUPPLIER S VALLEY HEALTH C	ENTER		STREET ADDRESS, CITY, STATE, ZIP CO 114 JEFFERSON STREET SOUTH BROWNS VALLEY, MN 56219		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 000	NFPA 13 the Stand Sprinkler Systems. alarm system with a smoke detection in The system is mon department notifica accordance with NI Alarm Code".	installed in accordance with ard for the Installation of The facility has a manual fire corridor smoke detection and spaces open to the corridors. itored for automatic fire tion and installed in FPA 72 "The National Fire	КС	000		
K 321 SS=D	census of 41on the NFPA 101 Hazardous Areas - 2012 EXISTING Hazardous areas a having 1-hour fire rated doors) or system in accordar approved automatic option is used, the other spaces by sm doors in accordance self-closing or autohave nonrated or fit that do not exceed the door. Describe the floor a hazardous areas the 19.3.2.1 Area Separation N/A a. Boiler and Fuel-F b. Laundries (larger c. Repair, Maintena	Enclosure re protected by a fire barrier esistance rating (with 3/4-hour an automatic fire extinguishing ice with 8.7.1. When the fire extinguishing system areas shall be separated from toke resisting partitions and e with 8.4. Doors shall be matic-closing and permitted to eld-applied protective plates 48 inches from the bottom of and zone locations of at are deficient in REMARKS. Automatic Sprinkler	K3	321		10/27/17
FORM CMS-25	567(02-99) Previous Versions	Obsolete Event ID: NJ392	1	Facility ID: 00668	continuation shee	et Page 3 of 10

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· '	DLE CONSTRUCTION 6 01 - MAIN BUILDING 01		E SURVEY PLETED
		245564	B. WING		09/1	19/2017
	PROVIDER OR SUPPLIER S VALLEY HEALTH C	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 114 JEFFERSON STREET SOUTH BROWNS VALLEY, MN 56219		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX T A G	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 321	(over 50 square feeg. Laboratories (if of Hazard - see K322) This STANDARD is Based on observatifacility failed to conaccordance with the (NFPA 101) section practice could allow corridor making it u	Rooms ons) rage Rooms/Spaces et) classified as Severe os not met as evidenced by: tion and staff interview the struct 2 hazardous rooms in e 2012 Life Safety Code, of 19.3.2.1.3. This deficient of for smoke or fire to enter the ntenable for exiting, affecting as and an undetermined	K 32	K321 - Housekeeping closet and Secondary O2 room will have clos devices installed by on or before 1 Andy Raw.		
K 341 SS=D	observations and sicloser's were missing room in the east with storage room in the storage room in the This deficient condition facility Administrate Environmental Service NFPA 101 Fire Alarm System A fire alarm system components approvaccordance with NF and NFPA 72, Nation provide effective was building. In areas needetection is installed.	ition was confirmed by the or and the Director of vices . m System - Installation	K 34			10/5/17

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION 01 - MAIN BUILDING 01		SURVEY PLETED
		245564	B. WING		09/	19/2017
	PROVIDER OR SUPPLIER S VALLEY HEALTH C	ENTER	1	TREET ADDRESS, CITY, STATE, ZIP CODE 14 JEFFERSON STREET SOUTH BROWNS VALLEY, MN 56219		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 341	and supervising sta	ance circuit power extenders, tion transmitting equipment. viring or other transmission d for integrity.	K 341			
	Based on observation facility failed to instruct accordance with NF (2012) section 19.3 National Fire Alarm This deficient practithe alarm system to during a fire event of the system of the system to during a fire event of the system of the	s not met as evidenced by: cions and staff interview the all the smoke detection in FPA 101 Life Safety Code .4.1, 9.6.1.3 and NFPA 72 Code (2010) section 17.7.4.1. Ice could affect the ability of a sound in a timely manner which could affect 4 of the 41 indetermined amount of risitors.		K341 - HVAC Diffuser was moved than 36 inches away from smoke of by Andy Raw on 10/5/17		
	interview revealed a	9/17 observations and staff a smoke detector in the east ess corridor doors was within AC diffuser.				
	Facility Administrate Environmental Serv	tion was confirmed by the or and the Director of vices . m System - Testing and	K 345			9/28/17
	A fire alarm system accordance with an	- Testing and Maintenance is tested and maintained in approved program complying its of NFPA 70, National				

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG 01 - Main Building 01	(X3) DATE COMP	SURVEY PLETED
		245564	B. WING		09/1	9/2017
	PROVIDER OR SUPPLIER S VALLEY HEALTH C	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 114 JEFFERSON STREET SOUTH BROWNS VALLEY, MN 56219		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETION DATE
K 345	and Signaling Code	NFPA 72, National Fire Alarm E. Records of system enance and testing are readily	K 3	45		
	Based on record refacility failed to mai system as required 2012 edition, section National Fire Alarm edition, section 14.3 could delay alarm refacility.	s not met as evidenced by: eview and staff interview the ntain the smoke detection by the Life Safety Code,(LSC) on 9.6.1.5 and NFPA 72, The and Signaling Code, 2010 3.1. This deficient condition notification in case of a fire sidents and an undetermined It visitors.		K345 – Fire Alarm inspection has completed by NARDINI FIRE und supervision by Andy Raw on 9/20 next inspection date will be monit Andy Raw. Inspection dates will be reviewed on a monthly basis goin forward.	der 8/17, cored by be	
	and staff interview	9/17 documentation review revealed an inspection of the been conducted within the last				
	Facility Administrate Environmental Services	ition was confirmed by the or and the Director of vices . r System - Maintenance and	К 3	53		10/9/17
	Automatic sprinkler inspected, tested, a with NFPA 25, Star	Maintenance and Testing and standpipe systems are and maintained in accordance dard for the Inspection, aining of Water-based Fire				

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	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE	E SURVEY PLETED
		245564	B. WING		09/1	19/2017
	PROVIDER OR SUPPLIER S VALLEY HEALTH (STREET ADDRESS, CITY, STATE, ZIP CODE 114 JEFFERSON STREET SOUTH BROWNS VALLEY, MN 56219		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETION DATE
K 372	maintenance, insp maintained in a se available. a) Date sprinkler b) Who provided c) Water system Provide in REMAR any non-required of system. 9.7.5, 9.7.7, 9.7.8, This STANDARD Based on observate facility failed to material accordance with the (NFPA 101) and N standard for testing systems. This definity systems. This definity systems allow for the spread undetermined amount of the spread undetermined amount of the systems. This deficient concility Administration it. This deficient concility Administration it.	s. Records of system design, ection and testing are cure location and readily system last checked system test supply source KKS information on coverage for or partial automatic sprinkler and NFPA 25 is not met as evidenced by: ation and staff interview, the intain the sprinkler system in the 2012 Life Safety Code FPA 25 section 5.2.1.1.2. The g and maintenance of sprinkler cient condition could cause the ot to function properly and d of fire. This could affect an ount of staff and visitors. 1/19/17 observations and staff the sprinkler head in the lower hine room had joint compound dition was confirmed by the tor and the Director of	K 353	K353 – NOVA SPRINKLER was to replace a sprinkler head with Jo Compound on it in the elevator maintenance closet, upon further inspection "Adam" with nova sprin indicated that it was not joint combut factory paint to indicate that it high temp (212 degree) sprinkler and will therefore not be replaced inspected on 10/09/2017	oint nkler pound was a head	10/5/17

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE COMF	SURVEY PLETED
		245564	B. WING		09/1	19/2017
	PROVIDER OR SUPPLIER S VALLEY HEALTH C	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 114 JEFFERSON STREET SOUTH BROWNS VALLEY, MN 56219		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX T A G	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 372	Construction 2012 EXISTING Smoke barriers shafire resistance ratin be permitted to terr Smoke dampers ar penetrations in fully an approved sprink smoke compartment barrier. 19.3.7.3, 8.6.7.1(1) Describe any mech in REMARKS. This STANDARD is Based on observational facility failed to mai barriers as required (NFPA 101) section deficient practice of from one smoke confecting the exiting an undetermined at Findings include: At 9:30 am on 09/1 interview revealed is barrier in the north doors did not have end of the conduit.	all be constructed to a 1/2-hour g per 8.5. Smoke barriers shall minate at an atrium wall. The not required in duct of ducted HVAC systems where ler system is installed for ents adjacent to the smoke shall make control system and staff interview the entain one of three smoke shallow smoke to transfer compartment to another shallow smoke to transfer compartment to another shallow shallow smoke to transfer compartment to another shallow shallow smoke to transfer compartment to another shallow shallo	K 372	K372 – Conduit above smoke bar been stopped up with proper fire ra caulking by Andy Raw and a check additional conduit has been condu 10/5/17	ated c for	10/4/17
SS=B	HVAC					

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245564	B. WING		·	09/	19/2017
	PROVIDER OR SUPPLIER			11	REET ADDRESS, CITY, STATE, ZIP CODE 4 JEFFERSON STREET SOUTH ROWNS VALLEY, MN 56219		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 521		n, and air conditioning shall ad shall be installed in ne manufacturer's	K s	521			
	Based on observation facility failed to mathroughout all residence 2012 Life Safety Cand NFPA 91 Stan Air Conveying of Value Noncombustible Parties deficient practical facility of the same of the sa	tice could negatively affect 34 and an undetermined amount			K521 – Bathroom Exhaust Units vinspected and repaired on 10/4/17 Andy Raw, Bath Fans will be monion a monthly basis by Andy Raw	by by	
		staff interview revealed the nroom fans in the east and					
K 711 SS=F	Facility Administra Environmental Ser	dition was confirmed by the tor and the Director of vices . tion and Relocation Plan	К	711			10/5/17
	patients and for the an emergency.	elocation Plan plan for the protection of all eir evacuation in the event of riodically instructed and kept					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 0 1		E SURVEY IPLETED
		245564	B, WING		09/	19/2017
	PROVIDER OR SUPPLIER S VALLEY HEALTH C	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 114 JEFFERSON STREET SOUTH BROWNS VALLEY, MN 56219		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ALASA BEREDENAED TO THE ADDDO	LD BE	(X5) COMPLETION DATE
K 711	copy of the plan is reperator or with sections and provides for all components per 18 18.7.1.1 through 18 18.7.2.3, 19.7.1.1 through 18 19.7.2.2, 19.7.2.3 This STANDARD is Based on record refacility failed to mai required in NFPA 10 edition section 19.7 could cause confus affect all 41 resider amount of staff and Findings include: At 8:20 am on 09/1 and staff interview in does not clearly additional conditions affect all 41 resider amount of staff and Staff interview in does not clearly additional conditions affect conditions and clearly additional conditions are staff interview in does not clearly additional conditions and clearly additional conditions are staff interview in does not clearly additional conditions are staff interview in does not clearly additional conditions are staff interview in does not clearly additional conditions are staff interview in does not clearly additional conditions are staff interview in does not clearly additional conditions are staff interview in does not clearly additional conditions are staff interview in does not clearly additional conditions are staff in the conditional conditions are staff in the condition conditions are sta	duties under the plan, and a readily available with telephone curity. The plan addresses the uired of staff per 18/19.7.2.1.2 of the fire safety plan /19.2.2. 3.7.1.3, 18.7.2.1.2, 18.7.2.2, 19.7.2.1.2, 19.7.2.2, 19.7.2.1.2, 19.7.2.2, 19.7.2.2, 19.7.2.2, 19.7.2.2, 19.7.2.2, 19.7.2.2, 19.7.2.2, 19.7.2.2, 19.7.2.2, 19.7.2.2, 19.7.2.2, 19.7.2.2, 19.7.2.2, 19.7.2.2, 19.7.2.2, 19.7.2.2, 19.7.2.2, 19.7.2.2	K 7	K711 – Fire & Evacuation plans been updated to include required data by Andy Raw on 10/5/17		