Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 31, 2023

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

RE: CCN: 245423
Cycle Start Date: August 24, 2023

Dear Administrator:

On October 5, 2023, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 14, 2023

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

RE: CCN: 245423
Cycle Start Date: August 24, 2023

Dear Administrator:

On August 24, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by November 24, 2023, (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by February 24, 2024, (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

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

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Cell: 1-507-308-4189

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING _____ B. WING _____	C 08/24/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 8/21/23, to 8/24/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1),	E 041		9/19/23

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

Electronically Signed | 09/22/2023

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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E 041	Continued From page 1 §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the	E 041		

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E 041	Continued From page 2 material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..	E 041		

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E 041	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide emergency generator testing in accordance with the 2012 Edition of Life Safety Code (NFPA 101), section 9.1.3.1, and the 2010 Edition of NFPA 110, Standard for Emergency and Standby Power Systems. Findings include: On 8/21/2023 between 9:30 AM to 1:30 PM, it was revealed by a review of available documentation, that the last documented inspection of the emergency generator was conducted on 7/17/2023. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	E 041	The Chosen Valley Care Center has policies and procedures addressing weekly testing of the emergency generator. To ensure timely testing, a computerized program automatically starts the generator test every Monday at 8:am. The system will sound an alarm at three different locations if the test fails. The facility has a 12-point weekly generator inspection protocol which includes a visual inspection of the condition of belts and hoses, liquid levels, general condition of the equipment, etc. Documentation of the inspection is recorded on the Emergency Generator Weekly Inspection Checklist which designates dates for the weekly check. The checklist shows weekly inspections for the past five weeks with the most recent inspection completed September 19, 2023. To ensure compliance with the weekly equipment checks, the Maintenance Director will audit the emergency generator testing spreadsheet monthly for six months and randomly thereafter. Compliance will also be reviewed during the monthly Quality Assurance and Performance Improvement Committee meetings and the quarterly Quality Assurance Committee meetings for twelve months. If noncompliance is noted, additional staff training and auditing will be done.	
F 000	INITIAL COMMENTS	F 000		

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F 000	Continued From page 4 On 8/21/23, to 8/24/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H54234663C (MN00094529) with a deficiency cited at F880. The following complaints were reviewed with NO deficiencies cited: H54234662C (MN00093080) H54234664C (MN00092670) H54234665C (MN00088529) H54234700C (MN00096121) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to	F 578		10/2/23

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F 578	Continued From page 5 formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the	F 578	Chosen Valley Care Center respects the	

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F 578	Continued From page 6 facility failed to ensure the resident's current wishes for resuscitation status were accurately documented in all areas of the medical record for 1 of 1 resident (R44) reviewed for advanced directives. Findings include: R44's Minimum Data Sheet (MDS) assessment, dated 7/23/23, indicated medical diagnoses of profound intellectual disabilities and seizures. R44 under guardianship. R44's electronic medical record (EMR) profile banner indicated R44's code status was do not resuscitate (DNR) and do not intubate (DNI). R44's hard chart had a cardiopulmonary resuscitation and do not resuscitate (CPR/DNR) consent form, dated 03/29/21 signed by R44's guardian and indicated R44's code status was cardiopulmonary resuscitation (CPR), meaning if resident's heart stopped staff should perform CPR. During an interview on 8/21/23 at 2:37 p.m., nursing assistant (NA)-A stated she would find a nurse for assistance if resident found unresponsive as she was not CPR trained. During an interview on 8/21/23 at 2:39 p.m., nursing assistant (NA)-B stated she would either find a nurse for assistance or perform CPR, NA-B was CPR trained, but would rely on nurse for finding code status. During an interview on 8/21/23 at 2:44 p.m., nursing assistant (NA)-C stated she would find a nurse for assistance if a resident was found	F 578	residents□ right to accept or refuse treatment and, at the resident□s option, formulate an advance directive. The facility has written policies and procedures addressing the resident□s choice of advance directives and preferences for end-of-life care. The policies addressing advance directives were reviewed. The procedures have been modified to instruct the staff that when there is a change in the resident□s code status, the current Provider Orders for Life-Sustaining Treatment (POLST) form in the paper record will be removed and replaced with an unsigned copy of the POLST form. Upon receipt of the POLST form with the provider□s signature, the unsigned copy will be removed and replaced with the signed copy. During mandatory education meetings, the licensed staff will be instructed on the importance that the documentation of the resident□s code status be consistent on the code status list at the nursing station, the code status designated on the resident□s electronic medical record identification banner, and the POLST form filed in the paper record. The importance of timely updates with code status changes will be addressed. For resident number 44, a POLST form signed by the medical provider indicating selective treatments with no intubation, advanced airway intervention or mechanical ventilation has been filed in her record. The code status, DNR/DNI selective treatments is documented on the electronic medical record resident	

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F 578	Continued From page 7 unresponsive. NA-C stated she was not CPR certified and would not look for code status on residents. During an interview on 8/21/23 at 2:53 p.m., licensed practical nurse (LPN)-A stated he looked in the EMR first, facility posted CPR status listing second, and then the resident's paper record for their Provider Orders for Life-Sustaining Treatment (POLST) form third to find a resident's code status in the case of an emergency. During an interview on 8/21/23 at 3:26 p.m., registered nurse (RN)-A stated she looked at a resident's profile banner in the EMR first, facility posted CPR status listing second, and then the resident's paper record for their POLST form third to find a resident's code status in the case of a medical emergency. RN-A indicated that the facility has a process for tracking, signing, and updating code status in charts when an updated code status form is presented. RN-A verified that R44's EMR banner, facilities CPR posting, and resident's paper record did not match. During an interview on 8/22/23 at 4:25 p.m., R44's patient guardian stated she signed an updated POLST on 8/16/23, to indicate the change to the DNR/DNI status. The form was signed by the RN case manager at facility the same day. During an interview on 8/24/23 at 1:36 p.m., social worker (SW) stated care managers handled POLST Forms and updates. SW stated updated POLST forms were sent to the attending physician to be reviewed and signed. Until that signed form was returned, she would hold an unsigned copy of the updated POLST Form.	F 578	identification banner. The resident□s advanced care preferences will continue to be reviewed during her quarterly care conferences. The records of all residents will be audited to ensure that the code status checked on the POLST form is consistent with the code status listed on the electronic medical record resident identification banner and the list of residents□ code status preferences posted at the nurses□ station. Compliance with consistent code status documentation will be monitored by the Social Worker/designee through audits of the records of new admissions for three months and on going random audits of current residents. If noncompliance is noted, additional audits and staff education will be done. Compliance will be reviewed during the upcoming quarterly Quality Assurance Committee meeting.	

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F 578	Continued From page 8 Once the updated POLST form was returned, she would upload a scanned copy to the EMR. SW stated that a mix up or confusion with a resident's code status could lead to the wrong treatment being administered in an emergency with the current system. During an interview on 8/24/23 at 2:27 p.m., acting director of nursing (DON) stated the resident's code status was found in three places, EMR on the banner, CPR posting at the nurses stations, and the resident's paper record. DON stated POLST forms were reviewed at admittance, care conferences, or whenever residents or guardians make an update. DON stated updated hard copy POLST forms were put into the resident's paper record once signed by the attending physician, but EMR status is updated once new code status is indicated. Acting DON further stated code status discrepancies in a resident's medical record was a big risk because they might perform CPR, and the resident may not want CPR, or vice versa. A policy regarding code status and advance directives was requested but not provided.	F 578		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		10/2/23

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	245423	A. BUILDING _____ B. WING _____	C 08/24/2023

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F 689	Continued From page 9 by: Based on observation, interview and document review, the facility failed to follow care plan interventions to prevent falls for 1 of 4 residents (R42) reviewed for accident hazards. Findings include: R42's quarterly Minimum Data Set (MDS) assessment, dated 7/30/23, indicated R42 was cognitively intact and had diagnoses of right lower extremity amputation, congestive heart failure (CHF), anemia, diabetes mellitus with left foot ulcer, atrial fibrillation, chronic obstructive pulmonary disease (COPD). Furthermore, R42's MDS indicated dependency for transfers as well as the need for extensive assistance with bed mobility, dressing, toilet use and hygiene. R42's care plan indicated a problem statement for risk for falls, including a risk for falling forward from chair if R42 bends over too far. Interventions included keep the wheelchair in reach with brakes locked when in room to reduce risk of falls. R42's progress note, dated 8/22/23, indicated an unwitnessed fall at 3:40 a.m. Resident was sitting up on the floor facing the doorway. Resident stated he was sitting in his chair, had finished using the urinal and he dropped it a little. He bent over to catch the urinal and fell face first onto the floor hitting the left side of his head. Room was well lit and free from clutter. Resident had Rooke Boot (medical device designed to protect the limb from additional trauma and offload the limb to assist in wound healing) on left foot. Right leg amputee. Call light was within reach. Wheelchair was not in front of resident's chair. Resident received a 5 cm by 5 cm hematoma "goose egg"	F 689	Chosen Valley Care Center has policies and procedures to ensure that the residents environment remains safe and as free of accident hazards as possible and that each resident receives adequate supervision and appropriate assistive devices to reduce the risk of accidents and injury. The facility identifies each resident at risk for accidents and develops a safety plan of care. The fall related policies and procedures were reviewed and found appropriate. The interdisciplinary care team comprehensively assesses each resident at the time of admission to identify safety risks and develops a resident-centered plan of care with interventions that enhance and promote safety. The resident s safety needs/risks are reassessed quarterly and whenever there is a change in the resident s mood/demeanor, physical condition, and/or cognition that could impact safety and functional status. The care plan is modified as necessary with the goal to attain maximum function with minimal risk of injury. The resident s safety interventions are communicated to the direct care staff during shift reports and through the nursing assistant care plans which are routinely updated. Resident number 42 has been reassessed for safe transfers. According to his preference, to assist in safe transfers and reduce the risk of falls, his locked wheel chair will continue to be placed within his reach when he is seated in his chair or in bed. His care plan was	

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F 689	Continued From page 10 on left side of forehead. No loss of consciousness. Speech is normal. Pupil response is a plus three. Hand grasp is strong. Resident placed in bed. Head elevated. Was resident sent to emergency department (ED) for evaluation? No. Fax notification sent to MD. Daughter notified. Case Manager, Nurse Manager and DON:: Fax sent. A progress note, dated 8/22/23 at 1:16 p.m., indicated a fall follow up R42: alert and oriented to person, place, and time, all neurological signs within normal limits. Resident does complain of headache. Resident has raised bruise to forehead and bruising around right eye. Will continue to monitor. Resident was seen by nurse practioner (NP)-A. During an observation and interview on 8/22/23 at 6:59 p.m., the center of R42's forehead had a raised area of about the two inches which was colored pink, red and purple. There were purple discolorations under both of R42's eyes. R42 stated he fell out of his wingback chair when he dropped the urinal and bent forward to catch it and landed on his face. During an observation on 8/23/23 at 2:03 p.m., R42 was sitting in wingback chair with his head down by his knees. Alerted nursing assistant (NA)-D who went to see if R42 needed to be scooted back in his chair. R42 stated, "no but I do need my wheelchair in front of this chair so that if I fall, I will fall into that chair". NA-D moved the wheelchair from the other side of the room to in front of R42 in the wingback chair. During an interview on 8/23/23 at 2:06 p.m., NA-D stated putting the wheelchair near R42	F 689	reviewed and updated accordingly. Changes in his ability to transfer will be communicated to his medical provider. During mandatory education meetings, the licensed nursing staff will be instructed on the need to develop and update as necessary the residents plan of care with a focus on safety and reducing the risk of falls. The certified nursing assistants will be reminded that their performance expectation includes being aware of and following the residents individualized plan of care for safe transfers that minimize fall risk. The safety plan of care for resident number 42 will be reviewed. To monitor compliance, for the next two weeks the case manager/designee will routinely observe for the appropriate placement of resident number 42's locked wheelchair when he is sitting in his wing back chair or in bed. During the analysis of causal factors that is routinely completed after each fall, the staff will continue to investigate whether safety interventions were in place and the residents plan of care was being followed. If noncompliance is noted with wheelchair placement for resident number 42 or if safety/risk management concerns are identified during the causal factor analysis of falls, additional monitoring and staff education will be done. Compliance will be reviewed at the quarterly October Quality Assurance Committee meeting.	

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F 689	Continued From page 11 wasn't on the care plan. During an interview on 8/23/23 at 2:14 p.m., registered nurse (RN)-A stated the resident care plans were in their closets, and when there was an update, it went in a binder and the nurses reviewed this in report. RN-A would expect an aid to look at the care plan and follow the care plan. During an observation on 8/23/23 at 2:47 p.m., R42 was sitting in wingback chair with his head down by his knees, R42's wheelchair was not near him. Alerted NA-A and she said to him "you want your chair in front of you?" and R42 said "of course". NA-A moved wheelchair into place in front of R42 from the other side of the room. During an interview on 8/23/23 at 2:49 p.m., NA-A stated was sure if there was an intervention for putting the wheelchair in place. NA-A checked the closet care plan and confirmed it said to put the wheelchair in reach with the brakes locked. During an interview on 8/23/23 at 3:53 p.m., the director of nursing (DON) stated following the care plan was important for preventing falls. The DON added when the case managers add interventions to a resident care plan there would be a notice on the board in the nurse's station that there was a change and that should prompt the aids to look at the resident's closet care plan. The DON also stated since R42 was seen in-house by NP-A after this fall, the facility would only send him in to the emergency department with any change in cognition or if he started having a decline in his abilities. During an interview on 8/24/23 at 4:10 p.m., the medical director (MD) didn't feel she could	F 689		

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F 689	Continued From page 12 comment on the care plan not being followed as a potential cause of this incident. The MD also stated R42 was on comfort care and had requested not to be sent to the emergency department. The MD's expectation was for the facility to do neurological checks and NP-A saw R42 in the facility on the day of the fall and he had been neurologically stable. A policy regarding fall prevention was requested but not received.	F 689		
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure menus and individual resident food plans met the nutritional needs and preferences for 1 of 1 resident (R3) reviewed for food and nutritional adequacy. Findings include: R3's Minimum Data Sheet (MDS) assessment, dated 06/25/23, indicated R3's diagnosis included Chronic obstructive pulmonary disease (COPD), anxiety, anemia, obesity, depression, hyperlipidemia, hypothyroidism, dementia. R3's current Physician Orders indicated R3 had orders for only ground meat to be served.	F 805	Chosen Valley Care Center has policies and procedures to ensure that food preparation and the residents meals are prepared and served in an appropriate manner to meet residents nutritional needs according to their assessment and plan of care. If a resident has difficulty chewing or swallowing, his/her food will be cut, chopped, ground, or pureed to reduce the risk of choking, encourage maximum therapeutic intake and promote a positive dining experience. The facility provides and serves food that is tasty, attractive, and at an appropriate temperature as determined by the food type. Being aware that improved nutrition and hydration status can help prevent or	10/2/23

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F 805	Continued From page 13 R3's care plan, dated 07/05/23, indicated only ground meat, no added salt (NAS) and no concentrated sweets (NCS) diet is to be served. Further reviewed assessments, dated 10/13/22, have a diet order for regular texture, mechanical meat. During observation on 08/22/23 at 6:29 p.m., R3's meal service revealed the presence of semi-soft menu items of mixed vegetables and minced ham on R3's plate. During observation on 08/23/23 at 8:03 p.m., R3's plate had a cheese omelet, toast, and two sausage links, whole, not cut up or ground. R3 was observed using a fork to cut the sausage links into small pieces. During an interview on 8/23/23 at 8:18 a.m., dietary aide (DA-A) verified that R3's menu ticket listed ground meat only. Furthermore, DA-A verified that R3 was served two whole sausage links and no ground meat. DA-A retrieved R3's menu ticket while speaking with surveyors to verify the resident's diet preferences/orders. During an interview on, 8/23/23 at 8:21 a.m., DA-A stated that kitchen and dietary staff were trained to follow the resident's meal ticket directions. During review of menu tickets, DA-A explained layout of tickets, which showed resident's name, date and meal period listed on top, selected menu items next, and at bottom of list special diet orders, which are color coded and printed in bold type face. During an observation on 8/24/23 at 11:30 a.m., cook reviewed individual resident menu tickets before food was plated and passed to aides to be	F 805	aid in the recovery from illness or injury, the goal of the facility is to provide appetizing food that meets nutritional needs with mechanical alteration as necessary to reduce the risk of choking. The policies and procedures for serving the continental style breakfast with hot and cold menu choices were reviewed and modified. To allow additional time for review of the diet restrictions/texture modifications listed on each resident□s menu card, the tasks of making toast, plating the resident□s hot food choices, and providing table service will be assigned to specific staff. The Director of Food and Nutritional Services will be provide mandatory education for the dietary staff on the 1) the changes in staff assignments/tasks and 2) importance of following the dietary restrictions/texture modifications listed on the resident□s menu card. Compliance will be monitored by the Director of Food and Nutritional Services/designee by observing for the appropriate mechanical alteration of food items five times per week for two weeks with random plate audits thereafter. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed at the quarterly October Quality Assurance Committee meeting. Please note, considering the menu of cheese omelet, toast and sausages, the 8/23/23 surveyor observation would have been at 8:03 a.m. rather than 8:03 p.m. as stated on the CMS 2567 form.	

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F 805	Continued From page 14 served. During an interview on 8/24/23 at 9:57 a.m., assistant assistant dietary manager (ADM) indicated menu tickets are color coded to the resident's special or preferred dietary needs and preferences. ADM also stated that both cooks and dietary aides should check that proper food is served. During an interview on 08/24/23 at 2:23 p.m., Acting Director of Nursing (DON) indicated that dietary staff should follow the resident's proper diet, diet orders on menu tickets. Further verified that non-compliance could lead to the resident choking on improper food. The facility policy and procedures manual, with the only date showing as 2021 (no month or day listed) showed that the facility would provide a therapeutic diet that was individualized to meet the clinical needs and desires of a patient/resident to achieve outcome/goals of care.	F 805		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		10/2/23

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F 880	Continued From page 15 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 16 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper hand hygiene and glove use was utilized in the dining area and during cares for 1 of 2 residents (R17) reviewed for dining. In addition, the facility failed to ensure staff labeled and dated tube feeding solution for 1 of 1 residents R44 reviewed for tube feeding. Findings include: R17's minimum data set (MDS) assessment dated 6/18/23 indicated R17 was cognitively intact. R17's diagnoses included: anemia, major depression, type 2 diabetes, neuropathy, osteoarthritis, restless legs, overactive bladder, presences, COPD, chronic pain, interocular lenses, and coronary artery disease. R17's care plan interventions included: two staff assist for transfers with a total body lift, eye protection used for transfers, and interventions to	F 880	Chosen Valley Care Center has established and maintains an infection prevention and control program (IPCP) designed to provide a safe, sanitary, and comfortable environment for staff, visitors and residents and to prevent the development and transmission of communicable diseases and infections. The infection control program includes 1) identifying, reporting, investigating, controlling, and preventing infections in the facility 2) determining the appropriate procedures, if any, that will be implemented for each resident with an infectious disease and 3) maintaining a record of incidences of infections and tracking any corrective actions taken. The IPCP is reviewed annually and updated as necessary. The facility□s infection control policies and procedures were reviewed and found appropriate. The policies address a system of surveillance to identify communicable diseases/infections before	

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F 880	Continued From page 17 prevent skin break down which included frequent repositioning and barrier cream. During an observation on 8/22/23 at 4:10 p.m., nursing assistant NA-(A) and NA-B entered R17's room and washed their hands at sink. NA-B pulled on the bedside table, and a lidded cup of water fell on the floor, and another cup tipped and leaked water onto R17's pants. NA-A placed the water cups onto R17's dresser. NA-B cleaned the water up off the floor. NA-A applied gloves. NA-B moved the total body lift into position. NA-A placed safety glasses on R17 and secured the lift straps. NA-A operated the lift and NA-B guided R17's body to center of bed. NA-A and NA-B removed straps, and log rolled R17 side to side to remove wet pants, underwear, and brief. NA-A and NA-B removed old gloves, sanitized hands at sink and applied new gloves. NA-A placed new pants on R17's lower legs and the two coordinated use of total body lift to move R17 from bed to the bathroom. NA-A removed gloves, washed hands at sink and put on new gloves. NA-B bagged up R17's wet garments. At 4:26 p.m. R17 stated her legs were not right on the toilet, NA-A applied gloves repositioned R17's legs and then removed gloves, washed hands at sink and applied new gloves. NA-B returned and washed hands at sink and applied new gloves. At 4:28 p.m. NA-A raised the lift and NA-B performed peri care with wipes and stated peri care would need to be completed once R17 was on the bed. NA-B removed gloves, washed hands at sink and applied new gloves. NA-A drove lift to bed and R17 was lowered to bed. R17 was rolled towards NA-A at window and NA-B cleaned R17's peri area with Wipes. NA-B	F 880	they can spread to other persons in the facility; when and to whom communicable diseases/infections should be reported; standard and transmission-based precautions to be followed to prevent the spread of infections; when and how isolation should be used for a resident; circumstances when an employee with a communicable condition/infection would be prevented from direct contact with residents or food; and hand hygiene after each direct resident contact for which hand cleansing is indicated by accepted professional practice. The facility□s policies and procedures for hand hygiene were reviewed and found appropriate. To encourage and facilitate hand hygiene during cares, hand sanitizer dispensers are located in the resident rooms and hallways. To promote a sanitary dining experience, hand sanitizer dispensers are located in the dining room and sanitary wipes are available at each table. During mandatory meetings, the nursing staff will be instructed on infection control techniques related to changing gloves and completing hand hygiene during the various resident care tasks. Labeling and dating of tube feeding solutions will also be addressed. The dietary staff will be instructed on the need for hand hygiene and glove changes between plating and serving food to different residents. Infection control techniques including hand hygiene and glove use are addressed during the new employee orientation and are included in the annual mandatory staff training.	

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F 880	Continued From page 18 grabbed barrier cream from the bathroom and applied it to R17's peri area. NA-B moved wipes and barrier cream aside and placed a new brief under R17. NA-B removed gloves. NA-B returned wipes to bathroom and sanitized hands. NA-A went into bathroom and sanitized hands, and left room. NA-A returned with a new sling. A new shirt was put on R17 at her request. R17 was rolled side to side to raise pants and place new lifting sling. At 4:43 p.m. NA-A placed the lift in the hallway and stated she would clean it when done. Both NA-A and NA-B washed hands in sink. R-17 was transferred to chair, and pillows and devices were placed around R17. NA-A took the water cups out of the room and explained she would have to go down to the kitchen to get replacements because one of the cups had fallen on the floor. At the start of continuous observation on 8/23/23 at 9:31 a.m., R17 was wheeled into her room, given her call light, and told staff would be in to help her. At 9:38 a.m., both NA-E and NA-D entered R17's room and sanitized hands. R17 stated she did not need to use the toilet. NA-E and NA-D secured total lift straps to R17's sling and NA-E operated the lift while NA-D guided R17's body over the bed. Both NA-E and NA-D applied gloves. R17 was rolled back and forth to get pants down. NA-E removed R17's pad and wiped peri area with wipes, and put a clean pad into place. Both NA-D and NA-E rolled R17 side to side to get pants into place. Before NA-E entered bathroom, NA-E moved R17's bedside table out of the way, then removed gloves and hand sanitized. NA-D also sanitized hands in the bathroom. NA-D and NA-E coordinated a transfer from bed to chair. NA-E and NA-D raised R17's legs, placed pillows under each arm and feet.	F 880	Resident number 17 was admitted to the facility on 10/5/17. She was transferred to the hospital September 1, 2023 where she died peacefully at age 97 with her family at her side. To monitor compliance, the Infection Preventionist/designee will observe nursing and dietary department staff hand washing practices three times weekly for one month, weekly for five months and once quarterly for six months. If noncompliance is noted, staff coaching and/or additional auditing and staff instruction will be done. Compliance with hand hygiene and glove use policies/techniques will be reviewed during the October 2023 quarterly Quality Assurance Committee meeting.	

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	245423	A. BUILDING _____ B. WING _____	C 08/24/2023

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

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F 880	Continued From page 19	F 880		

R17's safety glasses were removed, call light was placed on R17. A drink was offered to R17. NA-E placed bedside table and started an audio book on R17's Alexa device by voice command.

During an interview on 8/23/23 at 10:04 a.m. NA-E stated I should have taken my gloves off after peri-care and sanitized my hands before I touched the resident or things in the room, that would have been more sanitary and been better to prevent the spread of germs.

During a follow-up interview on 8/23/23 at 2:01 p.m., NA-B verified during cares she performed on 8/22/23, she did not perform hand hygiene after she completed R17's peri care and before she applied barrier cream to R17's peri area. NA-B stated she did not follow her normal routine and she should have sanitized her hands before she put on new gloves to prevent germs from spreading and to prevent the barrier cream from becoming contaminated.

During an observation on 8/23/23 at 11:26 a.m., (NA)-E and NA-C sanitized their hands and entered R27's room and closed the door. NA-E and NA-C put safety glasses on R17 and used a total body lift to transferred R17 from her recliner to her bed. Once R17 was on her bed, both NAs sanitized their hands and applied gloves. After R27's pants were lowered and pad was removed, NA-E removed gloves and sanitized hands and applied new gloves. R27 was transferred from bed to toilet with lift. PTA-A knocked and entered the room to observe the lift transfers. R17 stated she did not feel she was sitting right, so staff repositioned her two times.

At 11:43 a.m., R17 stated she was done, and the

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F 880	Continued From page 20 lift was raised. NA-E applied gloves and cleansed R17's peri area. R17 started to have a bowel movement (BM) while suspended in air in the sling. NA-E caught the BM with a wipe. NA-E threw the wipe away and R17 released more BM on to the floor. NA-E quickly wiped the BM up, grabbed another wipe and held it under R17 to catch additional BM. NA-E verified R17 was done and then disposed of the wipe. NA-E grabbed a new wipe, wiped R17's peri area, removed gloves, washed hands, and applied new gloves. NA-E and NA-C used the lift to transfer R17 from the bathroom to the bed. Once on the bed, a clean pad was placed, and NA-C and NA-E rolled R17 side to side to get pants into place. At 11:50 a.m., NA-E and NA-C removed gloves and hands sanitized. NA-E and NA-C used the lift to transfer R17 from the bed to her wheelchair. R17's body was arranged with support pillows, and she was offered a drink before PTA-A took R17 out of the room for therapy. During a follow-up interview on 8/23/23 3:47 p.m., NA-E stated they used a new wipe after they cleaned the floor however they should have stopped, washed their hands and applied new gloves after they touched the floor with a wipe and prior to using a new wipe on the resident. NA-E stated this would have been important to do to help prevent infection and the spread of germs from the floor to the resident. During an interview on 8/21/23 at 1:34 p.m., the Ombudsman stated R17's family had informed the facility they did not believe staff had been properly sanitizing their hands when caring for R17. The ombudsman stated the facility response had been that the facility had educated staff on handwashing and infection control.	F 880		

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F 880	Continued From page 21 During an interview on 8/23/23 at 3:04 p.m., the social worker and director of nursing (DON) stated R17's family had reported care concerns which included proper hand hygiene not being completed during cares of R17. The DON indicated with past concerns, the facility had conducted investigations and when indicated made care adjustments and or educated staff. The DON stated she would expect staff to remove gloves and sanitize hands after peri care and before touching the resident or other objects in the room. The DON staff should stop, remove gloves, and sanitize hands when they have completed peri cares. If a resident needs barrier cream, staff should apply new gloves after hand sanitization has occurred and then apply creams. The DON indicated anytime staff touch the floor, staff should sanitize hands (and apply new gloves if needed for cares) before touching the resident. The DON stated proper hand sanitization and glove use was necessary to protect residents and staff and to prevent the spread of infection and disease. During an observation on 8/23/23 at 8:20 a.m., dietary aide (DA)-A served two unidentified residents, one male, one female, without changing disposable gloves or washing hands in-between plating food. DA-A observed plating food without changing disposable gloves or washing hands. During an interview on 8/23/23 at 8:24 a.m., DA-A stated she wore gloves during meal service and changed them every six residents served, unless they needed to be changed before due to being soiled. DA-A stated she had received proper hand hygiene training for employment.	F 880		

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F 880	Continued From page 22 During an observation on 8/23/23 at 8:29 a.m., DA-A again served two residents, (R31 and an unidentified female) back-to-back, without changing gloves or washing hands between each individual food plating. During an observation on 8/23/23 at 8:39 a.m., DA-A served R19 and then plated another meal without changing gloves or washing hands in-between food plating. During an interview on 8/24/23 at 10:51 a.m., assistant dietary manager (ADM) stated the facility's hand washing policy and procedures should have been followed by all staff. ADM stated staff had been trained on proper hand hygiene upon hire and during other training's. ADM stated she expected staff to follow proper hand washing hygiene to change gloves as needed at all times. Review of the facility's policy and procedure manual for hand washing, dated 2021, (no month or day listed) indicated that employees would wash hands as frequently as needed throughout the day using proper hand washing procedures (and surrogate prosthetic device washing procedures as appropriate). Hand washing facilities would be readily available and equipped with hot and cold running water, paper towels, and/or automatic hand dryer, soap, trash cans, and signage outlining hand washing procedures. If chemical sanitizing gels were used, staff must first wash hands as outlined below. Hands and exposed portions of arms (or surrogate prosthetic devices) should be washed immediately before engaging in food preparation. When to wash hands:	F 880		

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F 880	Continued From page 23 a. When entering the kitchen at the start of a shift b. After touching bare human body parts other than clean hands and wrists. c. After using the restroom. d. After caring for or handling service animals or aquatic animals. e. After coughing, sneezing, using a tissue, using tobacco, eating or drinking. f. After handling soiled equipment or utensils. g. During food preparation, as often as necessary to remove soil or contamination and to prevent cross contamination when changing tasks. h. When switching between working with raw food and working with ready to eat food. i. Before donning disposable gloves for working with food and after gloves are removed. j. After engaging in other activities that contaminate the hands.	F 880		

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K 000	INITIAL COMMENTS FIRE SAFETY - BLDG 01 An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 10/11/2022. At the time of this survey, CHOSEN VALLEY CARE CENTER - BLDG 01 was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 10/18/2023

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

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

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K 000	Continued From page 2 (000) construction. In 2002, a canopy was constructed and was determined to be of Type V (111) construction. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The building is attached to Building 02, an addition constructed in 2020 which was determined to be of Type V(111) construction. There is a 2-hour fire-rated wall separating the two buildings and will therefore be surveyed as two buildings. The facility has a capacity of 78 beds and had a census of 73 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40	K 918		9/18/23

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K 918	Continued From page 3 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.4.2 and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, 8.3, 8.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/21/2023 between 9:30 AM to 1:30 PM, it was revealed by a review of available documentation, that the last documented weekly inspection of the emergency generator was	K 918	The Chosen Valley Care Center has policies and procedures addressing weekly testing of the emergency generator. To ensure timely testing, a computerized program automatically starts the generator test every Monday at 8:am. The program will alarm at three different locations if the test fails. The facility has a 12-point weekly generator inspection protocol which includes a visual inspection of the condition of belts and hoses, liquid levels, general condition of the equipment, etc. Documentation of the inspection is recorded on the Emergency Generator Weekly Inspection Checklist which designates dates for the weekly	

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K 918	Continued From page 4 conducted on 07/17/2023. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 918	check. The Emergency Generator Check list verifies weekly inspections for the past five weeks with the most recent inspection completed September 19. 2023. To ensure compliance, the Maintenance Director will audit the emergency generator testing spreadsheet monthly for six months and randomly thereafter. Compliance will also be reviewed during the monthly Quality Assurance and Performance Improvement and the quarterly Quality Assurance and Assessment Committee meetings for twelve months. If noncompliance is noted, additional staff training and auditing will be done.	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure.	K 920		10/20/23

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K 920	Continued From page 5 Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to manage the usage of electrical adaptive devices in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4 and NFPA 70, (2011 edition), National Electrical Code, sections 400-8. This deficient condition could have a patterned impact on the residents within the facility. Findings include: 1. On 08/21/2023 between 9:30 AM to 1:30 PM, it was revealed by observation that in a staff office (RM 039), a desk outlet bar was connected to a relocatable power strip. 2. On 08/21/2023 between 9:30 AM to 1:30 PM, it was revealed by observation that in RM 32 there were relocatable power strips daisy-chained together. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 920	Chosen Valley Care Center has policies and procedures that ensure the safe use of electrical adaptive devices including movable power strips. On August 22, 2023, all resident rooms and offices were inspected for proper use of movable electrical equipment including power strips. No problems were identified. To monitor the compliance of proper use of power strips, appropriate use of electrical devices will be included in the Safety Committee staff observation checklist. All rooms and offices will be inspected at least quarterly by a Safety Committee representative for appropriate use of electrical equipment. Any concerns will be reported to the Maintenance Director. A designated section of the Resident Handbook clearly explains that the use of extension cords and powers strips are not allowed in resident rooms. The housekeepers are aware of the regulations for use of power strips and extension cords and are instructed to report any concerns to their supervisor. The Director of Housekeeping has reminded the housekeepers to continue to be alert for improper use of electrical cords and strips in resident rooms and offices. Compliance with use of extension cords	

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K 920	Continued From page 6	K 920	and power strips will be reviewed ongoing by the Safety Committee and during the January 2024 quarterly Quality Assurance Committee meeting.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with	K 923		10/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/21/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 923	Continued From page 7 integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to identify locations of medical gas storage locations per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.6.5. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 08/21/2023 between 9:30 AM to 1:30 PM, it was revealed by observation that in the Med Gas Storage Room (RM 29) there was mixed storage of empty / full cylinders. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 923	Chosen Valley Care Center has policies and procedures addressing safe storage of oxygen cylinders. Empty cylinders are segregated from full cylinders. There are signs in the oxygen storage area instructing the staff on appropriate placement of empty and full cylinders. The signage will be enhanced to further prompt staff to properly segregate full and empty oxygen cylinders. The licensed nursing staff will be reminded of the need to segregate full and empty oxygen cylinders. The monitoring of oxygen storage will continue to be included as part of the routine quarterly Safety Committee staff observation rounds. To further monitor compliance with the proper oxygen storage, the Maintenance Technician will check the oxygen storage area for proper cylinder storage, including the separation of empty and full cylinders, weekly for three months. Compliance with oxygen storage regulatory policies will be reviewed ongoing by the Safety Committee and during the January 2024 quarterly Quality Assurance Committee meeting.	