Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 14, 2025

Administrator
Browns Valley Health Center
114 Jefferson Street South
Browns Valley, MN 56219

RE: CCN: 245564
Cycle Start Date: March 12, 2025

Dear Administrator:

On March 12, 2025, 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:

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 June 12, 2025 (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 September 12, 2025 (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)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: File

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March 14, 2025

Administrator
Browns Valley Health Center
114 Jefferson Street South
Browns Valley, MN 56219

Re: State Nursing Home Licensing Orders
Event ID: TFWZ11

Dear Administrator:

The above facility was surveyed on March 10, 2025 through March 12, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245564	A. BUILDING _____ B. WING _____	03/12/2025

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 3/10/25 to 3/12/25, a standard recertification 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 Part 483, Subpart B, Requirements for Long Term Care Facilities. Your 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. 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 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure professional standards of practice were followed during medication set-up and administration of insulin with a Humalog insulin pen (rapid-acting insulin, used to improve blood sugar control in people with diabetes mellitus) for 1 of 1 residents (R11) who received insulin without the pen primed according to manufacturer's recommendations.	F 760	BVHC will ensure all residents receiving insulin are free of significant medication errors. All nurses were educated on how to correctly give R11's insulin, by priming the pen according to the manufacturer's recommendations. All residents utilizing Insulin pens could be affected.	3/17/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/17/2025

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 760	Continued From page 1 Findings include: R11's significant change Minimum Data Set (MDS) dated 1/8/25, identified R11 had severe cognitive impairment and diagnoses which included arthritis, dementia, and diabetes mellitus (DM) and received injections of insulin. R11's care plan dated 10/7/24, identified R11 had DM and staff were to administer diabetic medications as ordered. R11's Order Summary Report signed 2/28/25, identified Humalog Kwik Pen 100 units per milliliter (ml) subcutaneous (an injection into the fatty tissue) per sliding scale (a scale that identifies how much insulin to administer per blood glucose readings) three times daily. Review of R11's treatment administration record (TAR) from 3/1/25 to 3/10/25, identified R11's blood glucose ranged from 177 to 347. Identified R11 received 2 to 8 units of Humalog insulin during this time period. During an observation on 3/10/25 at 4:38 p.m., registered nurse (RN)-A prepared R11's Humalog insulin RN-A removed the Humalog insulin pen from the medication cart, removed the tip, attached a needle to the end of the pen, dialed up 8 units of insulin picked up an alcohol wipe, went to R11's room and administered the 8 units of insulin to R11. RN-A then removed the needle from the end of the pen, placed it in the sharps container and sanitized her hands. RN-A did not prime the pen (waste 2 units of insulin to remove the air bubbles) per manufacturer's instructions prior to drawing up the 8 units of insulin.	F 760	All nursing staff were reeducated on Insulin pen administration policy and procedure. Nurses will be required to provide a competent return demonstration with another licensed nurse that has successfully completed the competency. The DON/designee will complete audits random audits of Medication pass for insulin will be conducted 3 x a week x 3 weeks, 2 x a week x 2 weeks, 1x a week x 2 weeks. If compliance is not achieved after completion of audits, staff will be reeducated, and audits will continue weekly until in compliance. Audits will start the week of March 24th, 2025. Audits will be reviewed at QAPI to provide further recommendations or additional auditing. Completion Date 4/18/25	

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F 760	Continued From page 2 During an interview on 3/109/25 at 4:44 p.m., RN-A verified she had not primed the insulin pen prior to dialing up the 8 units of Humalog for R11 per manufacturer's recommendations. RN-A stated she did not need to prime the pen because she had administered R11's insulin earlier in the day. During an interview on 3/11/25 at 9:30 a.m., consultant pharmacist (CP) stated it was important to always prime an insulin pen prior to drawing up the dosage to ensure the residents received the correct dosage of insulin. During an interview on 3/11/25 at 1:35 p.m., director of nursing (DON) stated her expectation was that the insulin pen would have been primed prior to dialing up the insulin dose for R12 to ensure the proper dose of insulin was administered. Review of Humalog insulin manufactures package insert dated 7/23, identified the need to prime the pen before drawing up the insulin. Identified priming the pen means removing the air from the needle and cartridge. Identified if you do not prime the pen before each injection, you may get too much or too little insulin. Review of a facility policy titled Medication Administration revised 8/7/23, identified the facility would ensure all medications were administered safely according to current standards of practice and regulatory requirements.	F 760		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		3/17/25

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F 812	Continued From page 3 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff wore hair restraints in the kitchen. Further, the facility failed to ensure food and beverages stored in the refrigerators, were labeled, dated and discarded properly. This deficient practice had the potential to affect all 28 residents who received food and beverages from the refrigerators and the kitchen. Findings include: Hair nets: On 3/10/25 at 12:02 p.m., dietary manager (DM) was standing at the dishwasher pulling clean dishes out of the dishwasher. DM hair was approximately 1/4 inch in length and was not	F 812	F812: Hairnets 1. The Dietary Manager will educate and train all staff on use of hair restraints in the kitchen according to the following: Training to be completed by 03/30/2025. a. CMS policy for hair restraint: i. Hair Restraints/Jewelry/Nail Polish □ According to the current standards of practice such as the Food Code of the FDA, food service staff must wear hair restraints (e.g., hairnet, hat, and/or beard restraint) to prevent hair from contacting food b. MN Food Code 4626.0115 HAIR RESTRAINTS. 2-402.11 i. A. Except as provided in item B, a food employee shall wear hair restraints,	

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F 812	Continued From page 4 wearing any type of a hair restraint. On 3/10/25 at 12:05 p.m., during the kitchen tour with the (DM), the following concerns were identified: Kitchen refrigerator: -Several slices of ham on a plate wrapped in saran wrap with a date of 2/28/25. Freezer -10 hamburger patty's in a bag without notation of an open date. Resident refrigerator and freezer on the unit: Fridge: -one slice of apple pie covered with saran wrap on a plate without notation of a date. -3/4 jar of salsa with a black crusty substance around the lid without notation of an open date. -1/4 container of mayonnaise without notation of an open date and an expiration date of 6/27/24. -1/2 jar of Queso cheese without notation of an open date. -3/4 bottle of Italian dressing without notation of an open date. -one ham sandwich on a plate covered with saran wrap without notation of a date. -one bowl of chili without notation of a date. -1/4 container of peppermint mocha creamer without notation of a date. Freezer: -half bag of pizza rolls without notation of an open date. -half bag of French fries without notation of an open date. -half bag of chicken nuggets without notation of an open date.	F 812	such as a hat, hair covering, or net, a beard restraint, and clothing that covers body hair. Hair restraints must be designed and worn to effectively keep hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles. B. This part does not apply to food employees such as counter staff who only serve beverages and wrapped or packaged foods, hostesses, or wait staff, if they present a minimal risk of contaminating exposed food. 2. The Dietary Manager and/or designee will monitor/audit hair restraint use daily starting the week of March 31st and will continue 2x week for 2 weeks, then weekly thereafter if compliance is achieved. If not achieved will re-educate staff. 3. Audit results will be brought to the QAPI committee quarterly for review and further recommendation as needed. 4. Completion Date: 4/18/25 F812: Kitchen Walk-in Cooler/Freezer Dietary Manager and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: 1. Initiate use of an updated resident refrigerator/freezer temperature log that will include daily checks of labeled foods and every three checks of expired foods. 2. Train all kitchen staff on perishable food management policy and procedures to check that food is labeled after opening. Training to be completed by 03/30/2025. 3. FDA Refrigerator & Freezer Storage	

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F 812	Continued From page 5 During an interview on 3/10/25 at 12:35 p.m., DM verified the above findings during the kitchen tour. DM stated his expectation was that all opened food should have been dated and thrown away after the shelf life or the expiration date. DM stated since his hair was not very long he was not aware he needed to wear a hair restraint in the kitchen. During an interview on 3/11/25 at 9:23 a.m., dietician stated her expectation was that all food items would have been dated once opened and thrown away after the shelf life or the expiration date to prevent a food borne-illness. Dietician further stated her expectation was that all all staff would have worn a hair restraint while in the kitchen. A facility policy titled Perishable Food Management reviewed 8/29/22, identified perishable foods were those likely to spoil, decay or become unsafe to consume if not refrigerated. Further, identified all food once opened should have been labeled, and dated when opened and include a use-by date or discard date. A facility policy titled Hair covering and restraints dated 1/31/2012, identified dietary staff must wear hair restraints (hairnet or bonnet) to prevent hair from contacting exposed food or clean dishes. Identified all of the hair needs to be covered.	F 812	Chart will be posted on cooler door as a reference tool for staff. 4. Random audits will be performed by the Dietary Manager and/or designee of proper labeling and dates of stored food. The Dietary Manager and/or designee started audits the week of ¿March 31st and will continue 2x/week for two weeks; then weekly thereafter if compliance is achieved. If not achieved will re-educate staff. 5. Audit results will be brought to the QAPI committee quarterly for review and further recommendation as needed. 6. Completion Date 4/18/25 F812: Resident refrigerator Dietary Manager and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: 1. Initiate use of an updated resident refrigerator/freezer temperature log that will include daily checks of labeled foods and every three checks of expired foods. 2. Train all staff including nursing on perishable food management policy and procedures to check temperatures and labels on foods and expiration dates. Training to be completed by 03/30/2025. 3. Random audits of proper storage and labeling of food will be completed. The Dietary Manager and/or designee started audits the week of ¿March 31st and will continue 2x/week for two weeks; then weekly thereafter if compliance is achieved. If not achieved will re-educate staff. 4. Audit results will be brought to the QAPI committee quarterly for review and	

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F 812	Continued From page 6	F 812	further recommendation as needed. 5. Completion Date 4/18/25	
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 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 §483.71 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;	F 880		3/17/25

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BROWNS VALLEY HEALTH CENTER	114 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 7 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the 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 and interview, the facility failed to disinfect a multi-use glucometer(a machine that is used for blood glucose monitoring) after use for 2 of 2 residents (R11, R6) reviewed for blood glucose monitoring. This deficient practice had the ability to affect all 9 residents who required blood glucose monitoring.	F 880	BVHC will ensure that shared equipment will be cleansed and disinfected in between residents. The glucometer that is used for multiple residents including R11 and R6, was disinfected and nursing staff was educated on how and when to disinfect	

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F 880	Continued From page 8 Findings include: The Centers for disease Control and Prevention (CDC) Infection Prevention for Blood Glucose Monitoring and Insulin Administration dated 2/6/2013, identified due to the risk of transmitting infectious diseases during assisted blood glucose (blood sugar) monitoring whenever possible, blood glucose meters should not be shared. If they must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions. R11 R11's significant change Minimum Data Set (MDS) dated 1/8/25, identified R11 had severe cognitive impairment and diagnoses which included, arthritis, dementia, and diabetes mellitus DM). Identified R11 required staff assistance with activities of daily living (ADL's). R11's current physicians orders signed 2/25/25, identified R11 required blood glucose monitoring checks three times daily. During an observation on 3/10/25 at 4:38 pm., registered nurse (RN)-A sanitized hands, applied gloves and removed a glucometer, strip and a lancet (small device with a needle used to get blood for blood glucose monitoring) from the top drawer of the medication cart. RN-A used the lancet to poke R11's finger and obtained a small drop of blood onto the glucometer strip. RN-A removed gloves and placed glucometer back into the medication cart without disinfecting the glucometer. RN-A proceeded to sanitize her hands and documented R11's blood glucose	F 880	the shared glucometer. All residents that require equipment for blood glucose readings have the potential to be affected by this. Education on cleaning and disinfecting equipment will be shared with Nursing Staff at an All Staff Inservice to discuss Cleaning and Disinfecting Resident Care Equipment and with review of policy. The DON/designee will complete audits on insulin administration 3 x a week x 2 weeks, 2 x a week x 2 weeks, and 1 x week x 2 weeks. If compliance is not achieved after completion of audits, staff will be reeducated, and audits will continue weekly until in compliance. Audits will start after All staff Inservice. Audits will be reviewed at QAPI to provide further recommendations or additional auditing. Completion Date 4/18/25	

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F 880	Continued From page 9 result on the computer. During an interview on 3/10/25 at 4:45 p.m., RN-A verified the glucometer was used for multiple residents. RN-A stated she should have disinfected the glucometer per manufacturer's guidelines prior to placing it into the drawer of the medication cart to prevent the spread of blood-borne infections. R6 R6's significant change MDS dated 1/25/25, identified R6 had moderate cognitive impairment and diagnoses which included dementia, renal insufficiency and DM. Identified R6 required staff assistance with ADL's. R6's current physicians orders signed 2/25/25, identified R6 required blood glucose monitoring checks three time daily on Monday, Wednesday, and Friday and as needed. During an observation on 3/10/25 at 6:47 p.m., licensed practical nurse (LPN)-A had done a blood glucose check using a glucometer on R6 in the common area on the unit. LPN-A walked to the cart and placed the glucometer in the top drawer. LPN-A was not seen disinfecting the glucometer. During an interview on 3/10/25 at 6:50 p.m., LPN-A verified the glucometer was used for multiple residents. LPN-A stated she had wiped the front of the glucometer with an alcohol wipe after doing R6's blood glucose monitoring. LPN-A stated she thought it was ok to use an alcohol wipe to disinfect the glucometer between residents. LPN-A stated she was unsure what the	F 880		

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F 880	Continued From page 10 manufacturer's suggested to use to disinfect the glucometers between resident use. During a joint interview on 3/11/25 at 1:25 p.m., infections preventionist (IP) and director of nursing (DON) verified the glucometer in the top drawer of the medication cart was used for several residents and DON stated using an alcohol wipe was not appropriate to disinfect the glucometer between resident use. IP and DON stated their expectation was that the glucometer would have been disinfected between residents using a Sani-wipe or per manufacturer's guidelines to prevent blood- borne infections. Review of Manufacturers guideline for Assure Platinum glucometer undated, identified disinfecting the glucometer was to be completed using a commercially available EPA-registered disinfectant detergent or germicide wipe, or one milliliter (ML) of household bleach to 9 (ML) of water to achieve a 1:10 dilution, or bleach wipes. Review of a facility policy titled Cleaning/ Disinfecting Resident Care Equipment reviewed 1/25/22, identified reusable resident equipment including glucometer was to be decontaminated between residents following manufactures instructions.	F 880		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/10/25 to 3/12/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE	2 000		

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2 000	Continued From page 2 IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21100	MN Rule 4658.0650 Subp. 5 Food Supplies; Storage of Perishable food Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure professional standards of practice were followed during medication set-up and administration of insulin with a Humalog insulin pen (rapid-acting insulin, used to improve blood sugar control in people with diabetes mellitus) for 1 of 1 residents (R11) who received insulin without the pen primed according to manufacturer's recommendations. Findings include: R11's significant change Minimum Data Set (MDS) dated 1/8/25, identified R11 had severe cognitive impairment and diagnoses which included arthritis, dementia, and diabetes mellitus (DM) and received injections of insulin. R11's care plan dated 10/7/24, identified R11 had DM and staff were to administer diabetic medications as ordered. R11's Order Summary Report signed 2/28/25, identified Humalog Kwik Pen 100 units per	21100	Corrected 4/18/25	3/17/25

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21100	Continued From page 3 milliliter (ml) subcutaneous (an injection into the fatty tissue) per sliding scale (a scale that identifies how much insulin to administer per blood glucose readings) three times daily. Review of R11's treatment administration record (TAR) from 3/1/25 to 3/10/25, identified R11's blood glucose ranged from 177 to 347. Identified R11 received 2 to 8 units of Humalog insulin during this time period. During an observation on 3/10/25 at 4:38 p.m., registered nurse (RN)-A prepared R11's Humalog insulin RN-A removed the Humalog insulin pen from the medication cart, removed the tip, attached a needle to the end of the pen, dialed up 8 units of insulin picked up an alcohol wipe, went to R11's room and administered the 8 units of insulin to R11. RN-A then removed the needle from the end of the pen, placed it in the sharps container and sanitized her hands. RN-A did not prime the pen (waste 2 units of insulin to remove the air bubbles) per manufacturer's instructions prior to drawing up the 8 units of insulin. During an interview on 3/109/25 at 4:44 p.m., RN-A verified she had not primed the insulin pen prior to dialing up the 8 units of Humalog for R11 per manufacturer's recommendations. RN-A stated she did not need to prime the pen because she had administered R11's insulin earlier in the day. During an interview on 3/11/25 at 9:30 a.m., consultant pharmacist (CP) stated it was important to always prime an insulin pen prior to drawing up the dosage to ensure the residents received the correct dosage of insulin. During an interview on 3/11/25 at 1:35 p.m.,	21100		

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21100	Continued From page 4 director of nursing (DON) stated her expectation was that the insulin pen would have been primed prior to dialing up the insulin dose for R12 to ensure the proper dose of insulin was administered. Review of Humalog insulin manufactures package insert dated 7/23, identified the need to prime the pen before drawing up the insulin. Identified priming the pen means removing the air from the needle and cartridge. Identified if you do not prime the pen before each injection, you may get too much or too little insulin. Review of a facility policy titled Medication Administration revised 8/7/23, identified the facility would ensure all medications were administered safely according to current standards of practice and regulatory requirements. SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee could ensure foods were stored and labeled properly to prevent potential degraded food served to residents of the facility, and hair restraints worn to prevent hair from contacting food. The facility could update or create policies and procedures, and educate staff on specific requirements or interventions related to food storage, labeling, and hair restraints. The administrator, registered dietician, or designee could perform audits for a designated amount of time as determined by the Quality Assurance Performance Improvement (QAPI) committee to ensure food items are stored and labeled appropriately, and hair restraints worn. The facility could report those findings to QAPI for further recommendations and determine the need for further monitoring or compliance.	21100		

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21100	Continued From page 5 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21100		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to disinfect a multi-use glucometer(a machine that is used for blood glucose monitoring) after use for 2 of 2 residents (R11, R6) reviewed for blood glucose monitoring. This deficient practice had the ability to affect all 9 residents who required blood glucose monitoring. Findings include: The Centers for disease Control and Prevention (CDC) Infection Prevention for Blood Glucose Monitoring and Insulin Administration dated 2/6/2013, identified due to the risk of transmitting infectious diseases during assisted blood glucose (blood sugar) monitoring whenever possible, blood glucose meters should not be shared. If they must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions. R11	21385	Corrected 4/18/25	3/17/25

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21385	Continued From page 6 R11's significant change Minimum Data Set (MDS) dated 1/8/25, identified R11 had severe cognitive impairment and diagnoses which included, arthritis, dementia, and diabetes mellitus DM). Identified R11 required staff assistance with activities of daily living (ADL's). R11's current physicians orders signed 2/25/25, identified R11 required blood glucose monitoring checks three times daily. During an observation on 3/10/25 at 4:38 pm., registered nurse (RN)-A sanitized hands, applied gloves and removed a glucometer, strip and a lancet (small device with a needle used to get blood for blood glucose monitoring) from the top drawer of the medication cart. RN-A used the lancet to poke R11's finger and obtained a small drop of blood onto the glucometer strip. RN-A removed gloves and placed glucometer back into the medication cart without disinfecting the glucometer. RN-A proceeded to sanitize her hands and documented R11's blood glucose result on the computer. During an interview on 3/10/25 at 4:45 p.m., RN-A verified the glucometer was used for multiple residents. RN-A stated she should have disinfected the glucometer per manufacturer's guidelines prior to placing it into the drawer of the medication cart to prevent the spread of blood-borne infections. R6 R6's significant change MDS dated 1/25/25, identified R6 had moderate cognitive impairment and diagnoses which included dementia, renal insufficiency and DM. Identified R6 required staff	21385		

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21385	Continued From page 7 assistance with ADL's. R6's current physicians orders signed 2/25/25, identified R6 required blood glucose monitoring checks three time daily on Monday, Wednesday, and Friday and as needed. During an observation on 3/10/25 at 6:47 p.m., licensed practical nurse (LPN)-A had done a blood glucose check using a glucometer on R6 in the common area on the unit. LPN-A walked to the cart and placed the glucometer in the top drawer. LPN-A was not seen disinfecting the glucometer. During an interview on 3/10/25 at 6:50 p.m., LPN-A verified the glucometer was used for multiple residents. LPN-A stated she had wiped the front of the glucometer with an alcohol wipe after doing R6's blood glucose monitoring. LPN-A stated she thought it was ok to use an alcohol wipe to disinfect the glucometer between residents. LPN-A stated she was unsure what the manufacturer's suggested to use to disinfect the glucometers between resident use. During a joint interview on 3/11/25 at 1:25 p.m., infections preventionist (IP) and director of nursing (DON) verified the glucometer in the top drawer of the medication cart was used for several residents and DON stated using an alcohol wipe was not appropriate to disinfect the glucometer between resident use. IP and DON stated their expectation was that the glucometer would have been disinfected between residents using a Sani-wipe or per manufacturer's guidelines to prevent blood- borne infections. Review of Manufacturers guideline for Assure Platinum glucometer undated, identified	21385		

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21385	Continued From page 8 disinfecting the glucometer was to be completed using a commercially available EPA-registered disinfectant detergent or germicide wipe, or one milliliter (ML) of household bleach to 9 (ML) of water to achieve a 1:10 dilution, or bleach wipes. Review of a facility policy titled Cleaning/ Disinfecting Resident Care Equipment reviewed 1/25/22, identified reusable resident equipment including glucometer was to be decontaminated between residents following manufactures instructions. SUGGESTED METHOD OF CORRECTION: Staff could be re-educated on infection control practices during glucometer cleaning. The director of nursing or designee could perform random audits to ensure staff are following infection control practices when cleaning a glucometer. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21385		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired	21545		3/17/25

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21545	Continued From page 9 medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure professional standards of practice were followed during medication set-up and administration of insulin with a Humalog insulin pen (rapid-acting insulin, used to improve blood sugar control in people	21545	corrected 4/18/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00668	A. BUILDING: _____ B. WING _____	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21545	Continued From page 10 with diabetes mellitus) for 1 of 1 residents (R11) who received insulin without the pen primed according to manufacturer's recommendations. Findings include: R11's significant change Minimum Data Set (MDS) dated 1/8/25, identified R11 had severe cognitive impairment and diagnoses which included arthritis, dementia, and diabetes mellitus (DM) and received injections of insulin. R11's care plan dated 10/7/24, identified R11 had DM and staff were to administer diabetic medications as ordered. R11's Order Summary Report signed 2/28/25, identified Humalog Kwik Pen 100 units per milliliter (ml) subcutaneous (an injection into the fatty tissue) per sliding scale (a scale that identifies how much insulin to administer per blood glucose readings) three times daily. Review of R11's treatment administration record (TAR) from 3/1/25 to 3/10/25, identified R11's blood glucose ranged from 177 to 347. Identified R11 received 2 to 8 units of Humalog insulin during this time period. During an observation on 3/10/25 at 4:38 p.m., registered nurse (RN)-A prepared R11's Humalog insulin RN-A removed the Humalog insulin pen from the medication cart, removed the tip, attached a needle to the end of the pen, dialed up 8 units of insulin picked up an alcohol wipe, went to R11's room and administered the 8 units of insulin to R11. RN-A then removed the needle from the end of the pen, placed it in the sharps container and sanitized her hands. RN-A did not prime the pen (waste 2 units of insulin to remove	21545		

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21545	Continued From page 11 the air bubbles) per manufacturer's instructions prior to drawing up the 8 units of insulin. During an interview on 3/109/25 at 4:44 p.m., RN-A verified she had not primed the insulin pen prior to dialing up the 8 units of Humalog for R11 per manufacturer's recommendations. RN-A stated she did not need to prime the pen because she had administered R11's insulin earlier in the day. During an interview on 3/11/25 at 9:30 a.m., consultant pharmacist (CP) stated it was important to always prime an insulin pen prior to drawing up the dosage to ensure the residents received the correct dosage of insulin. During an interview on 3/11/25 at 1:35 p.m., director of nursing (DON) stated her expectation was that the insulin pen would have been primed prior to dialing up the insulin dose for R12 to ensure the proper dose of insulin was administered. Review of Humalog insulin manufactures package insert dated 7/23, identified the need to prime the pen before drawing up the insulin. Identified priming the pen means removing the air from the needle and cartridge. Identified if you do not prime the pen before each injection, you may get too much or too little insulin. Review of a facility policy titled Medication Administration revised 8/7/23, identified the facility would ensure all medications were administered safely according to current standards of practice and regulatory requirements. SUGGESTED METHOD OF CORRECTION:	21545		

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21545	Continued From page 12 The director of nursing (DON) or designee could review and revise policies and procedures related to medication errors. The DON or designee could educate staff to ensure medications are correctly administered which may include but is not limited to the need for verifying orders and accurately transcribing. The DON or designee should review processes to ensure the pharmacist begins or maintains appropriate oversight of the medication administration process. The DON or designee could develop a system to verify compliance, such as auditing medication administration and or medical records for specific amount of days x___, then weekly x ___, then monthly x___, to gather appropriate data to ensure staff have corrected the concern or if further education would be required. Results of any actions and/or audits should be taken to the QAPI committee to determine compliance or the need for continued monitoring. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21545		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview and document	21685	corrected 4/18/25	3/17/25

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21685	Continued From page 13 review, the facility failed to ensure an environment that was free of accident hazards, related to hot water temperatures in 11 of 14 resident rooms (169, 158, 161, 151, 152, 153, 165, 166, 162, 157, 156), tested for safe water temperatures. This deficient practice had the potential to affect all 24 residents who used water from the water faucets in the affected area. Findings include: On 3/10/25 at 12:35 p.m., during resident screening the water temperatures in rooms 165, 169, 158 and 161, felt very warm to the touch after running water for one minute. During an observation and interview on 3/10/25 at 4:54 p.m., director of environmental services (DES)-A used the facility digital thermometer to measure the water temperatures in resident rooms. DES-A verified the water temperatures were above 115 degrees Fahrenheit (F) and resident hot water temperatures were to be maintained between 105 and 115 degrees F. DES-A indicated all resident rooms were supplied by the same water heater, except the far end of the hallway and the East wing. DES-A stated their water heater did not go below 120 degrees F and they would need to add mixing valves to the water heater to lower the hot water temperatures. Water temperatures were as follows: -room 169-116 degrees F. -room 158-117.4 degrees F. -room 161-117 degrees F. -room 151-116.2 degrees F. -room 152 -116.5 degrees F. -room 153-116.5 degrees F. -room 165-117.3 degrees F.	21685		

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21685	Continued From page 14 -room 166-117.3 degrees F. -room 162-117.5 degrees F. -room 157-118.1 degrees F. -room 156-118 degrees F. During an interview on 3/11/25 at 10:41 a.m., registered nurse (RN)-A indicated multiple residents were able to access their hot water, and some of those residents were cognitively impaired. During interview on 3/11/25 at 10:33 a.m., nursing assistant (NA)-A indicated multiple residents were able to access their hot water, and some of those residents were cognitively impairment. During an interview on 3/11/25 at 11:02 p.m., director of nursing (DON) indicated her expectation was the facility policy for water temperatures would be followed, so residents did not have burns. DON stated no residents had been burned by hot water. The facility policy titled Water Temperatures, revised 4/16/24, identified facility maintained, tested and recorded water temperatures at faucets and fixtures to mitigate the risk of burn injuries and spread of infection. The policy identified environmental services staff were responsible to maintain, test and record temperatures including equipment that controlled temperature in the hot water supply system. Resident rooms, bathrooms, tub/shower and common areas would be maintained to provide hot water temperatures between 105-115 degrees F. Hot water temperatures would not exceed 115 degrees F. SUGGESTED METHOD OF CORRECTION: The administrator, maintenance supervisor, or	21685		

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21685	Continued From page 15 designee could ensure hot water temperatures do not exceed 115 degrees for resident use, and a preventative maintenance program was developed to accurately reflect ongoing preventative maintenance scheduled or needed in the facility on a routine basis. The facility could create policies and procedures, educate staff on these changes and perform environmental rounds/audits periodically to ensure preventative maintenance is adequately completed. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21685		

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	245564	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/11/2025**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/11/2025. At the time of this survey, Browns Valley Health Center 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) Standard 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 CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/24/2025

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 HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail 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. Browns Valley Health Care is a 1-story building with a partial basement constructed at 2 different times. The original building was constructed in 1970 and was determined to be of Type II(111) construction. In 2001 an addition was added to the north that was determined to be of Type II(111) construction. Because the original building and the addition are of the same type of construction, meet the construction type allowed for existing buildings, the facility was surveyed as	K 000		

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K 000	Continued From page 2 one building. The building is fully sprinkler protected and the sprinkler system, and has a fire alarm system with corridor smoke detection and smoke detection in spaces open to the corridors. The fire alarm system is monitored for automatic fire department notification. The facility has a capacity of 35 beds and had a census of 28 on the day of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET.	K 000		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet)	K 321		3/17/25

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K 321	Continued From page 3 c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous area enclosures per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, 19.3.2.1.3, and 19.3.6.3.5. These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 03/11/2025 between 9:30 and 11:15 AM, it was revealed by observation that Rooms 115 and 117 were being used to store combustible items and did not have a self-closing device on the doors. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 321	K321 - On 03/11/2025 between 9:30 and 11:15 AM, it was revealed by observation that Rooms 115 and 117 were being used to store combustible items and did not have a self-closing device on the doors. Plan of correction, added self closing devices to room 115 and 117 doors on or before 3/28/25.	