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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: XPRO
Facility ID: 00668

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245564**
2. STATE VENDOR OR MEDICAID NO. (L2) **990343700**

3. NAME AND ADDRESS OF FACILITY
(L3) **BROWNS VALLEY HEALTH CENTER**
(L4) **114 JEFFERSON STREET SOUTH**
(L5) **BROWNS VALLEY, MN** (L6) **56219**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)
6. DATE OF SURVEY **10/02/2018** (L34)
8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

FISCAL YEAR ENDING DATE: (L35) **06/30**

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

12. Total Facility Beds **41** (L18)
13. Total Certified Beds **41** (L17)

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	41			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

A Life Safety Code Comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on 9/13/18 following a Minnesota Department of Health survey on 8/14/18.

A Post Certification Revisit(PCR) was completed by Minnesota Department of Health on October 2, 2018 and on October 12, 2018 an PCR was conducted by the Department of Public Safety and CMS. This facility is back in compliance.

17. SURVEYOR SIGNATURE — Date :
Susan Bachleitner, HFE - NE II — 10/18/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Joanne Simon, Enforcement Specialist — 10/30/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **06/01/1991** (L24)
23. LTC AGREEMENT BEGINNING DATE (L41)
24. LTC AGREEMENT ENDING DATE (L25)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

25. LTC EXTENSION DATE: (L27)
27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

28. TERMINATION DATE: (L28)
29. INTERMEDIARY/CARRIER NO. **03001** (L31)
30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)
32. DETERMINATION OF APPROVAL DATE **10/04/2018** (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245564

October 18, 2018

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

Dear Administrator:

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

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

Effective October 1, 2018 the above facility is certified for:

41 Skilled Nursing Facility/Nursing Facility Beds

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

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

cc: Licensing and Certification File

Electronically delivered
October 18, 2018

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

RE: Project Number S5564028

Dear Administrator:

On August 16, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), whereby corrections were required.

On September 13, 2018, a surveyor representing the office of the Centers for Medicare & Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility. As the surveyor informed you during the exit conference, the FMS revealed that your facility continued to not be in substantial compliance. The FMS found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On September 25, 2018, CMS forwarded the results of the FMS to you and informed you that your facility was not in substantial compliance with the applicable Federal requirements for nursing homes participating in the Medicare and Medicaid programs and imposed the following enforcement remedy:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 16, 2018. (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in their letter of September 25, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 16, 2018.

On October 2, 2018, the Minnesota Department of Health and on October 12, 2018 the Department of Public Safety and CMS completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to standard survey, completed on August 16, 2018. We presumed, based on your plan of correction, that your facility had corrected

these deficiencies as of October 1, 2018. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 16, 2018, as of October 1, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in their letter of September 25, 2018 the following actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 16, 2018, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective November 16, 2018, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective November 16, 2018, is to be rescinded.

In their letter of September 25, 2018, CMS advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 16, 2018, due to denial of payment for new admissions. Since your facility attained substantial compliance on October 1, 2018, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: XPRO
Facility ID: 00668

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245564**

2.STATE VENDOR OR MEDICAID NO.
(L2) **990343700**

3. NAME AND ADDRESS OF FACILITY
(L3) **BROWNS VALLEY HEALTH CENTER**
(L4) **114 JEFFERSON STREET SOUTH**
(L5) **BROWNS VALLEY, MN** (L6) **56219**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/16/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **41** (L18)
13.Total Certified Beds **41** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With
Program Requirements
Compliance Based On:
____1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	41			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
A Life Safety Code Comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on 9/13/18 following a Minnesota Department of Health survey on 8/14/18.

17. SURVEYOR SIGNATURE Date :
Christina Martinson, HFE - NE II 10/01/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 10/02/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
06/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 5, 2018

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

RE: Project Number S5564028

Dear Administrator:

On August 16, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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.

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

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

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

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 25, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 25, 2018 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

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

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

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. 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, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and 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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 16, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on

the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 16, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145

St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

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 ______	08/16/2018

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
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted March 6, 7, 8, 9, of 2018, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS 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 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.	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)	F 637		9/24/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 09/12/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245564	A. BUILDING ______ B. WING ______	08/16/2018

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 637	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete a Significant Change in Status Assessment (SCSA) within the fourteen day time frame when two or more areas of change in resident status were noted for 1 of 3 residents (R22) reviewed for a decline in health status. Findings include: R22's annual Minimum Data Set(MDS) dated 3/27/18, identified R22 had diagnoses which included hypertension (HTN), and gastroesophageal reflux disease (GERD). R22's quarterly MDS dated 6/20/18, identified R22 was independent with transfers, walking, locomotion on and off of the unit and toileting. The MDS identified R22 required extensive assistance with bed mobility, dressing, and personal hygiene. Further, the MDS listed R22 had occasional pain, which did not limit day to day activities. R22's hospital form titled Patient Care Summary dated 7/4/18, identified R22 had an acute, minimally displaced fracture of the right iliac wing. The summary instructed R22 to take Tylenol 500 mg (milligrams) every six hours, no weight bearing, and call if any problems. The facility form titled Physical Therapy dated 7/12/18, identified R22 had been referred to PT (physical therapy) following near fall during which resulted in right iliac wing fracture. PT recommended continued use of a full body lift due to non weight bearing status and for therapy to	F 637	Resident R22 received a comprehensive sig. change assessment due to changes in cognition. Appropriate individualized interventions were developed based on the results of the comprehensive significant change assessment. All residents will be reviewed to identify a need for comprehensive significant change assessments. Timely, accurate, comprehensive significant change assessments will be completed on residents identified with a significant change in condition. Significant Change in status Policies and Procedures were reviewed/revised . All staff involved with comprehensive significant change assessments will be re-educated on the process of identifying and completing a comprehensive significant change assessment on 9/20/18. Assessments will be monitored to ensure significant changes are appropriately identified and completed accurately and timely. A min of 3 records will be reviewed 3x wk x2, 2x wk x2 then weekly thereafter to ensure compliance. Staff will be re-educated on an ongoing basis as needed based on the results of the audits. The monitoring results will be reported monthly to the Performance Review team on 9/18/18 and quarterly to the QAPI team on 11/6/18. The QAPI team will make recommendations for ongoing monitoring. Completion date for F637 is Sep. 24th, 2018	

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 ______	08/16/2018

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 637	Continued From page 2 re-evaluate when cleared for weight bearing. On 8/13/18, at 1:53 p.m. R22 indicated she could no longer walk because of pain in her hip. R22 indicated the doctor had told her not to walk and not to go in the bathroom by herself. R22 stated, "There is hope it will heal and I can walk again." On 8/14/18, at 1:35 p.m. R22 sat in a wheel chair in a common area of the nursing home. R22 visited with staff while she handled the straps extending out between her legs from the full body mechanical lift sheet under her buttocks and legs. On 8/15/18, at 1:50 p.m. R22 was assisted to roll to her right side in bed by nursing assistant (NA)-A. NA-B then placed a bed pan for R22's toileting needs. On 8/15/18, at 11:19 a.m. NA-C stated R22 had been independent with most activities of daily living(ADL's) until she recently injured her hip. NA-C identified R22 was now non weight bearing and required the use of a full body lift, use of a bed pan and assistance with all other cares. On 8/15/18, at 1:54 p.m. NA-B identified R22 had been independent to walk with a walker until she injured her hip and now was non weight bearing and required staff assistance to transfer her with a full body lift and assistance with all other ADL's. On 8/16/18, at 8:40 a.m. licensed practical nurse (LPN)-A verified R22 had an X-ray of her hip on 7/4/18, and received an order for no weight bearing on that hip until healed. LPN-A identified currently R22's needs for staff assistance had changed from being mostly independent to needed assistance for toileting with a bed pan,	F 637		

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	245564	A. BUILDING ______ B. WING ______	08/16/2018

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BROWNS VALLEY HEALTH CENTER	**114 JEFFERSON STREET SOUTH BROWNS VALLEY, MN 56219**

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F 637	Continued From page 3 and staff to propel her in a wheel chair. On 8/16/18, at 9:11 a.m. registered nurse and MDS coordinator (RN/MDS)-E verified R22 used a full body lift for transfers, was non weight bearing, required total staff assistance for toileting with a bed pan and R22 had an increase in pain. RN/MDS-E stated a significant change MDS had not been completed because this was not a major decline for R22 that was not going to resolve itself. The RN/MDS-E stated the facility felt "it is a temporary change in status." On 8/16/18, at 11:38 a.m. the director of nursing (DON) indicated she and the MDS coordinators had reviewed R22's ADL changes, but did not feel a significant change MDS was needed. The facility policy titled MDS 3.0 Assessment revised 5/11/15, identified in section II. letter c) Significant change assessment - completed with 14 days of the identification of a status change that meets the requirements outlined in Chapter 2 of the 3.0 Version RAI Manual. i. A significant change is defined, according to the RAI Manual, MDS Version 3.0, as a decline or improvement in a resident's status that: 1) will not normally resolve itself without intervention by staff or implementing standard disease related clinical interventions, is not"self-limiting (for declines only); 2) Impacts more than one area of the resident's health status; AND 30 requires interdisciplinary review and/or revision of the care plan.	F 637		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		9/24/18

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F 656	Continued From page 4 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the	F 656		

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F 656	Continued From page 5 requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to implement care planned interventions for 1 of 1 residents (R32) with a bleeding disorder who was observed to have bruising. Findings include: R32's quarterly Minimum Data Set (MDS) dated 7/10/18, identified R32 had moderate cognitive impairment, had diagnoses which included thrombocytopenia(condition in which there is lower than normal platelets in the blood, which may result in easy bruising and excessive bleeding), heart failure, and diabetes. The MDS further identified R32 was independent with bed mobility, transfer, locomotion on and off of the unit, eating, toilet use and personal hygiene, required limited staff assistance to walk in room and corridor, and required extensive staff assist for dressing. R32's care plan revised 8/10/18, identified R32 was at risk for bleeding complications related to a diagnosis of relapsed idiopathic thrombocytopenic purpura (ITP) secondary to severe thrombocytopenia (a disease that may lead to excessive bruising and bleeding). R32's care plan included various interventions which included to protect from injury, monitor for bleeding, bruising, bloody nose, skin tears and report to physician if symptoms present and to inspect skin weekly. On 8/13/18, at 4:56 p.m. R32 sat in a wheelchair	F 656	Resident R32 received a skin inspection due to recent fall and bruising noted on her arm. Documentation set up weekly due to bruising being noted after a fall. New interventions are in place for follow-up documentation for all falls, skin injury/bruising. All residents will be reviewed to identify any care plan interventions that are not being implemented. Timely and accurate interventions will be implemented on residents after a fall or noted skin injury/bruising. Care Planning policy has been reviewed and found to be appropriate. All nursing staff will be re-educated on the process of identifying and implementing care plan interventions for falls and skin injury/bruising on 9/19/18 and 9/20/18. Interventions will be monitored to ensure implementations are appropriately identified and followed-up accurately and timely. A min. of 3 records will be reviewed 3x week for 2weeks, 2x week for 2weeks, then weekly thereafter to ensure compliance. Staff will be re-educated on an ongoing basis as needed based on the results of the audits. The monitoring results will be reported monthly to the Performance Review team on 9/18/18 and quarterly to the QAPI team on 11/6/18. The QAPI team will make recommendations for ongoing monitoring. Completion date for F656 is Sep. 24th, 2018	

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F 656	Continued From page 6	F 656		

in her room. R32 was noted to have a large dark purple bruise on the under side of her left forearm which extended from near the elbow to the middle of the forearm and a second smaller dark purple bruise higher on the left arm near R32's triceps. R32 indicated the bruises on her left arm were the result of a recent fall when she had attempted to get into her wheel chair. R32 did not offer any further information regarding her bruising.

Review of R32's progress notes were reviewed from 6/1/18, through 8/15/18, lacked documentation of R32's left arm bruising and lacked documentation of monitoring of the bruising to minimize adverse effects or excessive bleeding.

R32's clinical record lacked any documentation or monitoring of R32's left arm bruising.

On 8/16/18, at 8:45 a.m. licensed practical nurse (LPN)-A verified R32 had a bleeding disorder and it was important that her bruises be monitored. LPN-A indicated R32's care plan listed R32's need for skin issues including bruises to be monitored and skin to be inspected weekly. LPN-A reviewed R32's computer charting and verified the bruising on R32's left arm was not documented nor was it being reviewed weekly until healed as the facility policy directed.

On 8/16/18, at 11:14 a.m. LPN- A stated she had visualized R31's bruising at that time and stated the bruising on R32's forearm measured 11 cm (centimeters) x (by) 11 cm with a second bruise on her left triceps 5cm x 4 cm, abrasions to the left knee 3 cm x 1 cm, abrasion to the right knee 1. 5cm x 1 cm. She confirmed R32's large area of

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F 656	Continued From page 7 bruising had not been documented and monitored in the clinical record. LPN-A indicated the abrasions to knees were noted on the fall form dated 8/8/18; however, had not been added to the computerized skin condition report which triggered staff to monitor it until healed. On 8/16/18, at 11:30 a.m. the director of nursing (DON) indicated she would expect nursing assistants to see new skin issues including bruising when providing cares or assistance with dressing and the nursing assistants had been trained to report them. The DON indicated she expected staff to follow resident's care planned interventions and indicated monitoring of bruising would be important for a person with a bleeding disorder. The facility policy titled Care Planning revised 10/23/17, identified a comprehensive person centered care plan would be available to staff which would be consistent with the resident's rights, that included measurable objectives and time frames to meet the resident's medical, nursing, mental and psychosocial needs.	F 656		
F 814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure proper containment of garbage in the outside dumpsters to prevent harboring pests and rodents. This had the potential to affect all 39 residents residing in the facility.	F 814	Browns Valley Health Center will dispose garbage and refuse properly All residents have the potential to be impacted by a deficient practice in this area. Garbage disposal policy has been	9/24/18

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F 814	Continued From page 8 Findings include: On 8/13/18, at 1:55 p.m. during a tour of the facility kitchen area with dietary manager (DM)-A the facility's four dumpsters located in the back of building were observed. All four dumpsters were left uncovered. On 8/14/18, at 1:31 p.m. the four facility dumpsters were observed to be uncovered. The third dumpster had numerous white paper products, a large tin can, and two plastic water bottles which laid on the ground around it. A large white garbage bag was observed stacked on top of other garbage bags above the second dumpster's frame. On 8/15/18, at 6:59 a.m. all four facility dumpsters remained uncovered. The above garbage remained on the ground around the third dumpster and a black garbage bag was visible above the fourth dumpster's frame. On 8/15/18, at 8:14 a.m. housekeeper (HK)-A was observed to walk out of the facility's side entrance with two white garbage bags. She walked up to the second dumpster, threw the two bags into the uncovered dumpster and walked back into the facility. HK-A did not attempt to close the dumpster's lid. On 8/15/18, at 1:01 p.m. during an observation of the facility's dumpsters with environmental services (ES)-A, the four facility dumpsters remained uncovered. ES-A indicated the dumpsters were in "pretty tough shape" He stated the city of Browns Valley picked up the facility's garbage and he had called them on Monday to request replacement dumpsters, but had not	F 814	reviewed and found to be appropriate. 2 new 6 yard dumpsters with gravity weighted lids have been purchased All staff will be re-educated on the process of containing garbage in the dumpsters and closing lids by 9/20/18. Reminders will be posted on the dumpsters to not over fill and to close lids. Audits will be completed by DON/Designee 3x week for 2 weeks, then 2x week for 2 weeks, then weekly thereafter to ensure compliance. Staff will be re-educated on an ongoing basis as needed based on the results of the audits. The monitoring results will be reported to the monthly Performance Review team on 9/18/18and quarterly QAPI meeting on 11/6/18. The QAPI team will make recommendations for ongoing monitoring. Completion date for F814 is Sep. 24th, 2018	

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F 814	Continued From page 9	F 814		

heard back. The first two dumpsters had black plastic lids that remained functional. The third dumpster's lids had broken off and laid on the ground behind the dumpster. The fourth dumpster marked "Kitchen Only" had one lid that was broken/bent that remained on the hinge on the right hand side, but was not functional. The left side lid was missing. ES-A observed the garbage on the ground, picked up two plastic water bottles, acknowledged the remaining paper products and tin can, and threw the two plastic water bottles in a dumpster. He closed the two dumpster lids that were able to be closed. ES-A indicated the garbage around the dumpsters was picked up weekly, when doing lawn care. ES-A stated he would expect staff to close the dumpster lids that were able to be closed, but "honestly, they are closed maybe half the time."

On 8/15/18, at 1:08 p.m. HK-A stated the facility dumpsters were "always open" and some of the lids were broken and could not close.

On 8/15/18, at 1:16 p.m. the administrator stated the facility's garbage was picked up from the city of Sisseton, South Dakota, and the facility had been working with them for awhile trying to get new dumpsters. The adminstrator indicated the facility was at risk for pests and rodents with the current condition of the dumpsters.

On 8/15/18, at 1:22 p.m. cook (CK)-A indicated the "Kitchen Only" dumpster was for food scraps. CK-A stated the dumpster could not close as the lid was broken and missing.

On 8/16/18, at 8:14 a.m. the tin can and paper products remained around dumpster three. Dumpster two's lid remained open due to the lid

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F 814	Continued From page 10 being propped up by two large black garbage bags. Review of a facility policy tilted Disposal of Garbage, revised 6/4/18, indicated to not over fill outdoor dumpsters and assure dumpster lids are closed.	F 814		

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

F5564026

PRINTED: 09/17/2018
FORM APPROVED
OMB NO. 0938-0391

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	245564	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**08/14/2018**

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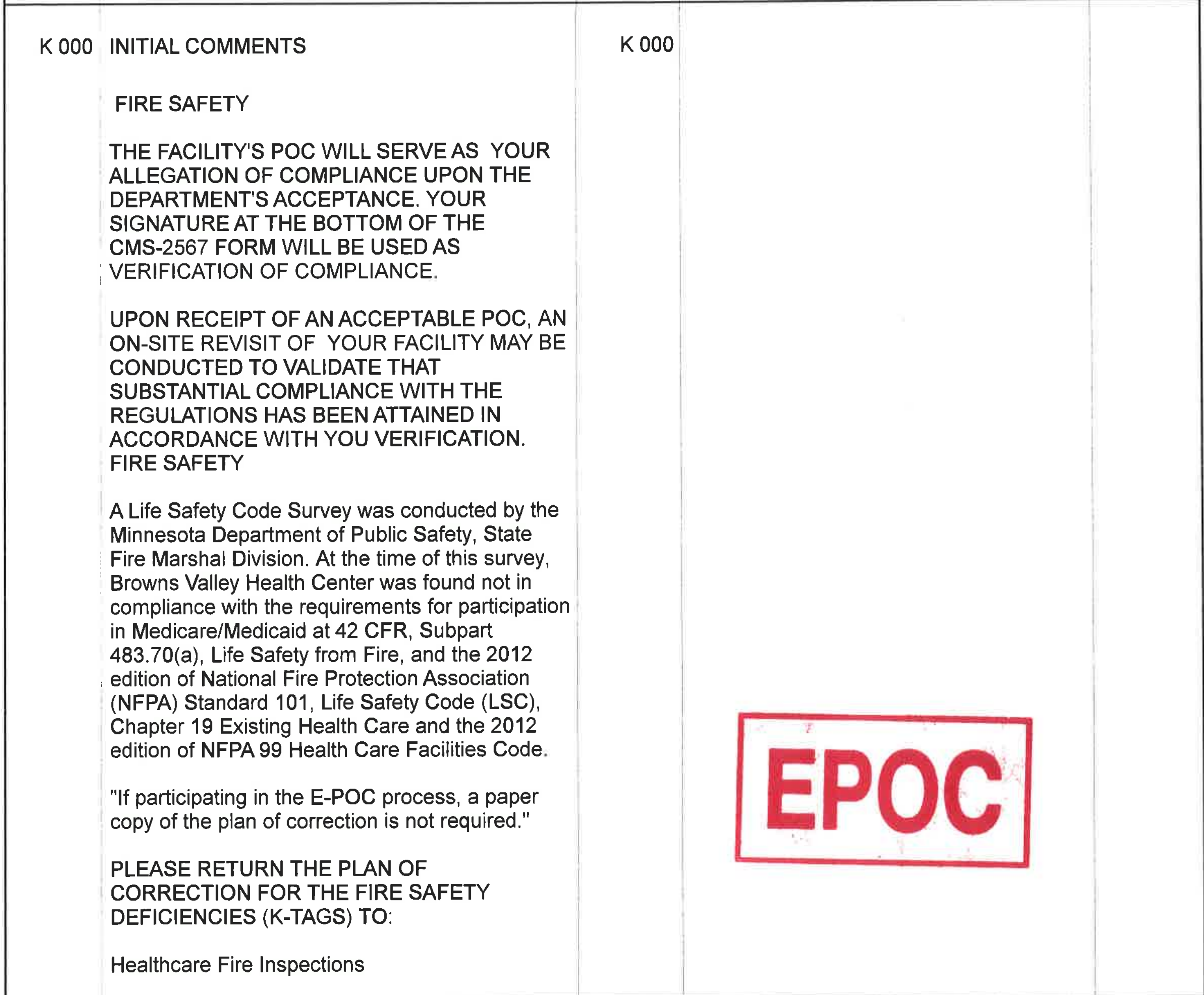

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE 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 YOU VERIFICATION. FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. 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. "If participating in the E-POC process, 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: Healthcare Fire Inspections	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/12/2018

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	K 000		

State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

Or by email to:
Marian.Whitney@state.mn.us
and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

"If participating in the E-POC process, a paper copy of the plan of correction is not required."

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Browns Valley Health Care is a 1-story building with a partial basement. The building was 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 and is protected by a fire sprinkler system. Because the original building and the addition are of the same type construction, meet the construction type allowed for existing buildings, the facility was surveyed as one building.

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	245564	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**08/14/2018**

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
K 000	Continued From page 2 The building is fully sprinkler protected and the sprinkler system is installed in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems. The facility has a manual fire alarm system with corridor smoke detection and smoke detection in spaces open to the corridors. The system is monitored for automatic fire department notification and installed in accordance with NFPA 72 "The National Fire Alarm Code". The facility has a capacity of 41 beds and had a census of 39 on the day of the survey.	K 000		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____________ b) Who provided system test _____________ c) Water system supply source _____________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K 353		9/10/18

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K 353	Continued From page 3 Based on observation and staff interview, the facility failed to maintain the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101) and NFPA 25 section 5.2.1.1.2. The standard for testing and maintenance of sprinkler systems. This deficient condition could cause the sprinkler system not to function properly and allow for the spread of fire. This could affect 27 of 41 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 9:30 am to 1:00 pm on 08/14/2018 observations revealed; 1. The kitchen contained 4 sprinkler heads covered in dirt and lint. 2. Three ceiling tiles missing from the grid in a storage room across from the nurses station in the north wing. 3. A ceiling tile in the admissions office with a 4 inch hole in it. 4. In resident room 113 the closet contained storage within 18 inches of the sprinkler head. This deficient condition was confirmed by the Facility Administrator.	K 353	Sprinkler dust and blockage: Sprinklers will be checked twice per year for obstruction and dust build up and cleaned/cleared accordingly an audit sheet will be created sprinklers will be cleaned as of 9/10/18. Ceiling /tiles in nurse's station storage room: Will be fastened in such way as to not become loosened over time. Admission room tile: tile has been replaced. Resident room 113: belongings have been moved from the above storage closest to a lower storage and basement storage. All was completed on 09/10/2018	
K 521 SS=D	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2	K 521		9/5/18

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 521	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain proper exhaust throughout all resident wings as required by the 2012 Life Safety Code (NFPA 101) section 9.2.2 and NFPA 91 Standard for Exhaust Systems for Air Conveying of Vapors, Gases, Mists and Noncombustible Particulate Solids. This deficient practice could negatively affect 6 of the 41 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 9:30 am to 1:00 pm on 08/14/2018 observations revealed the east wing bathroom fans were not operable. This deficient condition was confirmed by the Facility Administrator .	K 521	Air Exchange room 139: It was not known to ESD that fan was separate from room 138. HVAC fan will be repaired and placed on its own checklist and checked once per month. This will be done by 09/10/2018	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7	K 712		9/10/18

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K 712	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to instruct all employees in life safety procedures as required by the Life Safety Code (NFPA 101) 2012 edition, section 19.7.1.8. This deficient practice could reduce the ability of staff to conduct a safe and timely response to a fire emergency, which would affect all 41 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 9:30 am to 1:00 pm on 08/14/2018 record review revealed 4 of the last 12 months of fire drills did not have the signatures of staff to verify participation in the drills. This deficient condition was confirmed by the Facility Administrator .	K 712	Fire drill signatures: Charge nurses will be trained by 9/10/18 to require signatures on back of fire drill sheet and will be double checked upon receipt by ESD after drills. Completed 09/10/18	
K 922 SS=D	Gas Equipment - Other CFR(s): NFPA 101 Gas Equipment - Other List in the REMARKS section any NFPA 99 Chapter 11 Gas Equipment requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 11 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to provide the proper medical equipment to hold compressed gas cylinders for in use as prescribed in NFPA 99 (12) Health Care	K 922	O2 Tank for D.C.: Nursing will be properly trained on acceptable methods of mounting an O2 container to a resident walker to ensure stability, completed on	8/14/18

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K 922	Continued From page 6 Facilities Code section 11.3.3.3. This deficient practice could cause injury if the cylinder fell, affecting an undetermined amount of residents, staff and visitors. Findings include: On the facility tour between 9:30 am to 1:00 pm on 08/14/2018 observations revealed an E sized cylinder in use on a resident walker and not properly secured. This deficient condition was confirmed by the Facility Administrator .	K 922	08/14/18.	