DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
December 27, 2023

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

RE: CCN: 245423
Cycle Start Date: November 6, 2023

Dear Administrator:

On December 19, 2023, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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December 27, 2023

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

Re: Reinspection Results
Event ID: 86S412

Dear Administrator:

On December 19, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on November 6, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 28, 2023

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

RE: CCN: 245423
Cycle Start Date: November 6, 2023

Dear Administrator:

On November 6, 2023, a survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 February 6, 2024, (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 May 6, 2024, (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Please contact me with any questions regarding this letter.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING _____ B. WING _____	C 11/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 11/6/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H54236900C (MN00097270) with NO deficiency cited. AND H54236902C (MN00098142, MN00098039) with a deficiency issued at F760 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that 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 interview, and document review, the facility failed to ensure medications were administered in accordance with physician orders to reduce the risk of adverse disease-associated	F 760	Chosen Valley Care Center provides pharmaceutical services to meet the needs of each resident. The provision of pharmaceutical services is an integral part	12/15/23

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

Electronically Signed | 12/06/2023

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

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F 760	Continued From page 1 complications for 1 of 1 resident (R1) reviewed for medication errors. Findings include: A vulnerable adult report submitted to the State Agency dated 10/30/23, identified a medication error occurred when R1 received her chemotherapy medication temozolomide on day 1-5 instead of on days 10-14 of her chemotherapy cycle. "This would cause increased nausea and vomiting and risk of developing cytopenias (low levels of red blood cells (anemia), white blood cells (leukopenia) or platelets.) in 1-2 weeks after the medication error." R1's admission Minimum Data Set (MDS) dated 10/9/23, indicated R1 was cognitively intact and had diagnoses of cancer. R1's physician order dated 10/2/23, indicated R1 had a follow-up oncology appointment on 10/19/23 to determine chemotherapy Cycle #2. The tentative order for chemotherapy regimen to start on 10/20/23, included temozolomide 200 milligrams (mg) at bedtime on days 10-14 of 28 cycle & Capecitabine 1000 mg twice daily on days 1-14 of 28-day cycle. Take 30 minutes (min) after meal, whole with water, do not crush or break. The order indicated the clinic pharmacy would fill and send out the medications pending the results of the 10/19/23, appointment. R1's medical Oncology office visit note dated 10/19/23, identified R1 returned for toxicity assessment prior to starting cycle 2 of chemotherapy. Progress note identified R1's decline in her performance status has stabilized	F 760	of the resident care and services provided by the Chosen Valley staff. The goal of the facility is that residents will be free of significant medication errors and that the risk of adverse consequences associated with medication use will be minimized. The staff are aware of the increased risk of adverse consequences to all residents due to complex medication regimens as well as the large numbers and types of medications ordered, physiological changes accompanying the aging process, and multiple comorbidities. The overall goal of the facility's pharmaceutical services is to ensure the safe and effective use of medications while minimizing the risk of medication errors. The facility has developed policies and procedures to ensure successful management of complex medication regimens which include processes that facilitate accurate administration of medications, maintain accurate and timely medication records, and minimize medication-related adverse consequences or events. The facility has contracted with a licensed consultant pharmacist, who in collaboration with the medical director and facility staff, establishes, evaluates and coordinates all aspects of resident pharmaceutical services including the accurate acquiring, receiving, dispensing, storing and administering of drugs and biologicals. The nurses and the consultant pharmacist consider the characteristics of the resident population and individual	

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F 760	Continued From page 2 over the last several weeks and included R1's appetite had been better when she was activity taking chemotherapy. R1 tolerated her 1st cycle of chemotherapy. The note indicated to continue the same chemo regimen. The records included the following orders: -Capecitabine (Xeloda) take 1000 mg (two 500 mg tablets) by mouth two times a day for 28 doses. Take on days 1 through 14 of each 28 day cycle. Take within 30 minutes after a meal. Swallow whole with water. Do not crush or cut (dates 9/18/23-11/16/23) -Temozolomide (Temodar) take 200 mg (two 100 mg capsules) by mouth at bedtime for 5 days. Take on days 10 through 14 of each 28 day cycle (dates 10/19/23-11/16/23) temozolomide (Temodar) 100 mg capsule take 200 mg (two 100 mg capsules) by mouth at bedtime for 5 days. Take on days 10-14 of each 28 day Cycle. Starting 10/19/23 until 11/16/23. In review of R1's physician orders and medication administration record (MAR) dated 10/1/23-10/31/23, identified the orders were not transcribed into R1's record as written by oncology. R1's physician orders and MARs included the following: -"temozolomide oral capsule 100 mg. Give 2 capsule by mouth at bedtime related to malignant neoplasm (term for a cancerous tumor) of endocrine pancreas, secondary malignant neoplasm of liver and intrahepatic bile duct (network of small tubes that carry bile inside the liver) for 5 days." Start date 10/20/23 (no end date was identified.) -Capecitabine. oral tablet 500 mg give 2 tablets by mouth two times a day related to malignant neoplasm of endocrine pancreas secondary malignant neoplasm of liver and intraptic bile duct	F 760	resident conditions when developing medication-related policies and procedures that help ensure safe and accurate medication administration according to the prescriber's orders as well as ensure compliance with applicable state and federal requirements and manufacturers' specifications. The facility's medication administration related policies and procedures were reviewed and revised. Orders for chemotherapy medications are now to be verified by a registered nurse clinical manager. The registered nurses were educated on the policy change. Resident number 1 was admitted October 2, 2023 with a diagnosis of metastatic pancreatic cancer. Due to a transcription error, the resident received a chemotherapy medication on days one through five (October 20-24) of the 28-day treatment regimen cycle rather than days ten through fourteen as ordered. The attending physician, oncology provider, consultant pharmacist and the family were immediately notified. The resident was closely monitored for side effects including nausea, vomiting and decreased platelets. As reported, the resident's attending physician was "unable to say if the medication error caused on adverse outcome as the resident was already very ill and was surprised the second cycle of chemotherapy medication was even started related to Resident #1's weakness and nausea." (The resident was receiving medication to treat nausea	

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F 760	Continued From page 3 until 11/3/2023 12:59 take within 30 minutes after meal. Swallow whole with water. Do not brush (sic) or crush. Start date 10/20/23 (no end date was identified.) The MAR identified temozolomide was started on the 1st day of the cycle instead of the 10th day. R1 received both Capecitabine 1000 mg and temozolomide on 10/20/23, 10/21/23, 10/22/23, 10/23/23, and 10/24/23; those days R1 should have only received Capecitabine. R1's clinical communication dated 10/25/23, at 11:44 a.m. indicated director of nursing (DON) called Rochester department of Oncology (the study of cancer). Reason for call: DON stated R1's temozolomide was started on "day 1" instead of waiting until day "10." Facility stated the error had not been caught until that day (10/25/23) which would have been "day 5." The facility indicated they were not sure how to proceed and wanted a response. R1's clinical communication dated 10/25/23, at 3:13 p.m. response from provider indicated since medication was not given on the correct schedule to proceed and give temozolomide tonight since that would be "day 5." DON indicated R1 was also experiencing significant nausea and had been receiving Zofran (medication for nausea) twice a day with one as needed dose throughout the day. It was explained that R1 should also have a compazine (medication used for nausea) available for breakthrough nausea. Facility was encouraged to rotate between Compazine and Zofran to optimize nausea control. During an interview on 11/6/23, at 11:47 a.m. Oncology provider (OP) stated after R1's visit with her on 10/19/23, R1 was supposed to start her	F 760	at the time of admission.) After the resident's October 17, 2023 physician appointment, the resident was sent to the emergency department due to concerns regarding hypotension; she was subsequently admitted to the hospital. The resident died at the hospital October 29. 2023. The events surrounding the administration of the resident's chemotherapy medication were reviewed by Chosen Valley Care Center administrative staff as part of the facility's quality improvement process. To monitor compliance, during the next 10 days, the Director of Nurses/designee will monitor the accuracy of transcription of medication orders requiring two staff accuracy verification (chemotherapy, anticoagulant and insulin medications). If noncompliance is noted during the audits, additional auditing and staff education will be done. Random audits of accuracy of orders listed on the medication administration record will be ongoing. Medication errors are routinely reviewed during the monthly Quality Assurance and Performance Improvement Committee meetings. Compliance will be reviewed during the January quarterly Quality Assurance Committee meeting.	

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F 760	Continued From page 4 2nd 28 day chemo cycle. OP stated the prescription identified the start date of the chemo medication was the beginning of the cycle; the order was for the 2 medications to be given in tandem, first Capecitabine then temozolomide. OP stated because this medication was not given as ordered the biggest side effect would have been increased nausea and vomiting. OP relayed because this medication has a small window to which it could be effective and because the medication had not been given in that small window there was no way for sure to know that this event caused a negative outcome. OP indicated the first medication (Capecitabine) prepared the body's DNA for the second medication (temozolomide); giving the temozolomide too early would potentially not have allowed the temozolomide to work appropriately. During an interview on 11/6/23, at 12:17 p.m. clinical manager (CM)-B indicated she had printed off R1's chemotherapy orders from the hospital health record. CM-B stated the order indicated the medication was to start on 10/19/23, but the medications received until 10/20/23, so CM-B started them right away. CM-B stated she had not followed the directions on the order and just followed the start date that was indicated on the medication order. CM-B stated she had read the order for temozolomide and Capecitabine and put them into the EMAR at the facility but was not sure what the cycle dates were. CM-B stated she was not aware of a medication error until the DON had informed her but was unable to recall the exact date the DON had informed her. During an interview on 11/6/23 at 2:13 p.m., director of nursing (DON) stated R1's family expressed concerns related to temozolomide's	F 760		

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F 760	Continued From page 5 start date. DON stated she looked into R1's hospital portal to find the original order for the medication in question. DON stated the order indicated a start date of 10/19/23 and the medication was given on 10/20/23. DON identified the directions indicated the medication was to start on day 10 of the cycle and 10/30/23 should have been the start date of the temozolomide order. DON stated the nurse transcribing the order should have gotten clarification as the order was confusing. During an interview on 11/6/23 at 3:54 p.m., pharmacy consultant stated DON contacted her right away related to the temozolomide medication error. Pharmacy consultant was unable to determine if the medication error would have any negative outcomes as she was not familiar with the medication. Pharmacist stated she had looked into the medication information software and found the medications given to R1 did not indicate complications nor did she find any possible contraindications related to the medication error. Pharmacist reported both medications are chemotherapy medications and have something to do with DNA meaning the first chemo drug does something to the DNA and the second chemo drug would be able to complete the process. Pharmacist stated she would anticipated potential side effects of the medications given at the same time would be anorexia and nausea as well as decreased platelets. During an interview on 11/6/23 at 4:57 p.m., R1's physician stated R1 was weak and nauseous before the medication error and she and the facility were trying different interventions to treat said nausea. Physician stated she was unable to	F 760		

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F 760	Continued From page 6 say if the medication error caused an adverse outcome as the resident was already very ill and was surprised the second cycle of chemo-medication (medication used to treat cancer) was even started related to R1's weakness and nausea. Facility policy titled, Medication Administration-General Guidelines, dated 4/1/19, indicated medications are to be administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Preparations included, five rights-right resident, right drug, right dose, right route, and right time, are applied for each medication being administered. Procedures, the prescriber is contacted by nursing to verify or clarify an order (e.g., when the resident has allergies to the medication, there are contraindications to the medication, significant drug interactions are present, the directions are confusing.)	F 760		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 28, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: 86S411

Dear Administrator:

The above facility was surveyed on November 2, 2023, through November 6, 2023, 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:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 contact me with any questions regarding this letter.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00750	A. BUILDING: _____ B. WING _____	C 11/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 11/6/23, a complaint 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. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaints were reviewed H54236900C (MN00097270) found in compliance AND The following complaints were reviewed. H54236902C (MN00098142) H54236902C (MN00098039) with a deficiency issued at 1545 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 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm 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.	2 000		

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
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 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	21545		12/15/23

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21545	Continued From page 3 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 interview, and document review, the facility failed to ensure medications were administered in accordance with physician orders to reduce the risk of adverse disease-associated complications for 1 of 1 resident (R1) reviewed for medication errors. Findings include: A vulnerable adult report submitted to the State Agency dated 10/30/23, identified a medication error occurred when R1 received her chemotherapy medication temozolomide on day 1-5 instead of on days 10-14 of her chemotherapy cycle. "This would cause increased nausea and vomiting and risk of developing cytopenias (low levels of red blood cells (anemia), white blood cells (leukopenia) or platelets.) in 1-2 weeks after the medication error."	21545	Corrected	

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21545	Continued From page 4 R1's admission Minimum Data Set (MDS) dated 10/9/23, indicated R1 was cognitively intact and had diagnoses of cancer. R1's physician order dated 10/2/23, indicated R1 had a follow-up oncology appointment on 10/19/23 to determine chemotherapy Cycle #2. The tentative order for chemotherapy regimen to start on 10/20/23, included temozolomide 200 milligrams (mg) at bedtime on days 10-14 of 28 cycle & Capecitabine 1000 mg twice daily on days 1-14 of 28-day cycle. Take 30 minutes (min) after meal, whole with water, do not crush or break. The order indicated the clinic pharmacy would fill and send out the medications pending the results of the 10/19/23, appointment. R1's medical Oncology office visit note dated 10/19/23, identified R1 returned for toxicity assessment prior to starting cycle 2 of chemotherapy. Progress note identified R1's decline in her performance status has stabilized over the last several weeks and included R1's appetite had been better when she was activity taking chemotherapy. R1 tolerated her 1st cycle of chemotherapy. The note indicated to continue the same chemo regimen. The records included the following orders: -Capecitabine (Xeloda) take 1000 mg (two 500 mg tablets) by mouth two times a day for 28 doses. Take on days 1 through 14 of each 28 day cycle. Take within 30 minutes after a meal. Swallow whole with water. Do not crush or cut (dates 9/18/23-11/16/23) -Temozolomide (Temodar) take 200 mg (two 100 mg capsules) by mouth at bedtime for 5 days. Take on days 10 through 14 of each 28 day cycle (dates 10/19/23-11/16/23) temozolomide (Temodar) 100 mg capsule take 200 mg (two 100	21545		

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21545	Continued From page 5 mg capsules) by mouth at bedtime for 5 days. Take on days 10-14 of each 28 day Cycle. Starting 10/19/23 until 11/16/23. In review of R1's physician orders and medication administration record (MAR) dated 10/1/23-10/31/23, identified the orders were not transcribed into R1's record as written by oncology. R1's physician orders and MARs included the following: -"temozolomide oral capsule 100 mg. Give 2 capsule by mouth at bedtime related to malignant neoplasm (term for a cancerous tumor) of endocrine pancreas, secondary malignant neoplasm of liver and intrahepatic bile duct (network of small tubes that carry bile inside the liver) for 5 days." Start date 10/20/23 (no end date was identified.) -Capecitabine. oral tablet 500 mg give 2 tablets by mouth two times a day related to malignant neoplasm of endocrine pancreas secondary malignant neoplasm of liver and intraptic bile duct until 11/3/2023 12:59 take within 30 minutes after meal. Swallow whole with water. Do not brush (sic) or crush. Start date 10/20/23 (no end date was identified.) The MAR identified temozolomide was started on the 1st day of the cycle instead of the 10th day. R1 received both Capecitabine 1000 mg and temozolomide on 10/20/23, 10/21/23, 10/22/23, 10/23/23, and 10/24/23; those days R1 should have only received Capecitabine. R1's clinical communication dated 10/25/23, at 11:44 a.m. indicated director of nursing (DON) called Rochester department of Oncology (the study of cancer). Reason for call: DON stated R1's temozolomide was started on "day 1" instead of waiting until day "10." Facility stated the error had not been caught until that day	21545		

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21545	Continued From page 6 (10/25/23) which would have been "day 5." The facility indicated they were not sure how to proceed and wanted a response. R1's clinical communication dated 10/25/23, at 3:13 p.m. response from provider indicated since medication was not given on the correct schedule to proceed and give temozolomide tonight since that would be "day 5." DON indicated R1 was also experiencing significant nausea and had been receiving Zofran (medication for nausea) twice a day with one as needed dose throughout the day. It was explained that R1 should also have a compazine (medication used for nausea) available for breakthrough nausea. Facility was encouraged to rotate between Compazine and Zofran to optimize nausea control. During an interview on 11/6/23, at 11:47 a.m. Oncology provider (OP) stated after R1's visit with her on 10/19/23, R1 was supposed to start her 2nd 28 day chemo cycle. OP stated the prescription identified the start date of the chemo medication was the beginning of the cycle; the order was for the 2 medications to be given in tandem, first Capecitabine then temozolomide. OP stated because this medication was not given as ordered the biggest side effect would have been increased nausea and vomiting. OP relayed because this medication has a small window to which it could be effective and because the medication had not been given in that small window there was no way for sure to know that this event caused a negative outcome. OP indicated the first medication (Capecitabine) prepared the body's DNA for the second medication (temozolomide); giving the temozolomide too early would potentially not have allowed the temozolomide to work appropriately.	21545		

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21545	Continued From page 7 During an interview on 11/6/23, at 12:17 p.m. clinical manager (CM)-B indicated she had printed off R1's chemotherapy orders from the hospital health record. CM-B stated the order indicated the medication was to start on 10/19/23, but the medications received until 10/20/23, so CM-B started them right away. CM-B stated she had not followed the directions on the order and just followed the start date that was indicated on the medication order. CM-B stated she had read the order for temozolomide and Capecitabine and put them into the EMAR at the facility but was not sure what the cycle dates were. CM-B stated she was not aware of a medication error until the DON had informed her but was unable to recall the exact date the DON had informed her. During an interview on 11/6/23 at 2:13 p.m., director of nursing (DON) stated R1's family expressed concerns related to temozolomide's start date. DON stated she looked into R1's hospital portal to find the original order for the medication in question. DON stated the order indicated a start date of 10/19/23 and the medication was given on 10/20/23. DON identified the directions indicated the medication was to start on day 10 of the cycle and 10/30/23 should have been the start date of the temozolomide order. DON stated the nurse transcribing the order should have gotten clarification as the order was confusing. During an interview on 11/6/23 at 3:54 p.m., pharmacy consultant stated DON contacted her right away related to the temozolomide medication error. Pharmacy consultant was unable to determine if the medication error would have any negative outcomes as she was not familiar with the medication. Pharmacist stated she had looked into the medication information	21545		

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21545	Continued From page 8 software and found the medications given to R1 did not indicate complications nor did she find any possible contraindications related to the medication error. Pharmacist reported both medications are chemotherapy medications and have something to do with DNA meaning the first chemo drug does something to the DNA and the second chemo drug would be able to complete the process. Pharmacist stated she would anticipated potential side effects of the medications given at the same time would be anorexia and nausea as well as decreased platelets. During an interview on 11/6/23 at 4:57 p.m., R1's physician stated R1 was weak and nauseous before the medication error and she and the facility were trying different interventions to treat said nausea. Physician stated she was unable to say if the medication error caused an adverse outcome as the resident was already very ill and was surprised the second cycle of chemo-medication (medication used to treat cancer) was even started related to R1's weakness and nausea. Facility policy titled, Medication Administration-General Guidelines, dated 4/1/19, indicated medications are to be administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Preparations included, five rights-right resident, right drug, right dose, right route, and right time, are applied for each medication being administered. Procedures, the prescriber is contacted by nursing to verify or clarify an order (e.g., when the resident has allergies to the medication, there are contraindications to the medication, significant drug interactions are present, the directions are	21545		

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21545	Continued From page 9 confusing.) SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for medication errors. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure medications were correctly administered. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21545		