DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 8, 2023

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

RE: CCN: 245423
Cycle Start Date: March 29, 2023

Dear Administrator:

On May 3, 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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

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May 8, 2023

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

Re: Reinspection Results
Event ID: 3FIS12

Dear Administrator:

On May 3, 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 March 29, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 11, 2023

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

RE: CCN: 245423
Cycle Start Date: March 29, 2023

Dear Administrator:

On March 29, 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 June 29, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 29, 2023 (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.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@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 03/29/2023

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 3/28/23 and 3/29/23, 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 complaint was reviewed. H54239842C (MN00092284) with a deficiency issued at F609 The following complaint was reviewed with no deficiency issued H54239618C (MN00091999). 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 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2	F 609		4/26/23

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

Electronically Signed | 04/13/2023

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

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F 609	Continued From page 1 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to report allegations of verbal/mental abuse to the State Agency within two hours for 1 of 1 resident (R1) reviewed for allegations of mental/emotional abuse. Findings include: A Facility Reported Incident (FRI) submitted to the State Agency on 3/27/2023, at 9:21 a.m., alleged emotional or mental abuse by a staff member that had occurred on 3/24/2023. According to the report the nursing assistant (NA)-A was reported to be verbally rude to R1 and the staff member had been suspended pending investigation. During an interview on 3/29/23 at 1:15 p.m., NA-B	F 609	Chosen Valley Care Center policies address that each resident will be free from abuse, neglect, mistreatment, exploitation and misappropriation of property. Chosen Valley Care Center seeks to offer the highest quality care and treatment for each resident, providing a safe and secure environment free from abuse and neglect. The facility provides instructions on abuse investigation and reporting which includes, “If the incident involves abuse, neglect, or suspicion of a crime with serious bodily injury, the incident must be reported immediately but not later than 2 hours after forming the suspicion or time of incident.” The policy also addresses protection of the alleged victim, mandated	

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F 609	Continued From page 2 stated she was asked by NA-A to assist her with R1 on 3/24/23. NA-B reported that NA-A had been verbally aggressive and cursing at R1 during the cares she was providing. NA-B stated she had reported her concerns with NA-A to licensed practical nurse (LPN)-A on 3/25/23 at around 2:45 p.m. NA-B reported an unawareness she should have reported the incident right away. During an interview on 3/29/23 at 4:13 p.m., LPN-A stated NA-B reported to her on 3/25/23, that she had overheard NA-A swearing at a resident on 3/24/23. LPN-A explained she had told NA-B to write the incident down and turn it in to management. NA-B had reported she was concerned about retaliation from NA-A for reporting her, so LPN-A directed NA-B to sign her (LPN-A's) name to the report. LPN-A indicated she had not read the written report that NA-A submitted on 3/25/23. LPN-A indicated she had not reported the allegations to the State Agency after NA-B reported to her. An undated written statement that indicated it was authored by LPN-A, indicated that licensed practical nurse (LPN)-A was the one helping NA-A with R1's cares. The report further indicated LPN-A heard NA-A using profanity, belittling statements, and cursing at R1 while both LPN-A and NA-A were providing cares to him. The statement also included accusations of NA-A cursing at R1 for kicking the mechanical lift. During an interview on 3/29/2023 at 12:53 p.m., social worker (SW) stated she was informed of the verbal abuse allegations towards R1 on the morning of 3/27/23 that had happened on 3/24/23. SW stated NA-A was suspended pending investigation on 3/27/23, she then	F 609	reporter, and alleged perpetrator. A copy of the Abuse Prevention Policy is provided to all staff upon hire for review. All staff also complete Abuse Prevention training through Healthcare Academy annually. Compliance with this regulation positively impacts all residents. The facility's Abuse Prevention Policies and Procedures were reviewed and found appropriate. During the admissions process, the Social Worker informs residents and their representatives of the facility's Abuse Prevention Program in the Resident Handbook. Abuse prevention is also reviewed annually by Social Services during Resident Council. Resident Number R1 - Upon discovery of the alleged violation, the Social Worker interviewed the alleged victim. Resident gave a thumbs up when asked how he was and if he felt safe. The Director of Social Services spoke with the resident's guardian March 27th, 2023. According to the guardian, there were no changes in mood or behavior noted by family. Staff caring for R1 were also interviewed and did not note any changes in resident's behavior or affect. The Social Worker also interviewed other residents not involved in the allegation who denied any concerns of abuse. The staff were re-educated on abuse and neglect, including timely reporting, during department specific meetings, shift report, and a quiz during the week of March 27th, 2023. All staff will be required to review and acknowledge the Abuse Prevention Policies and Procedures. The Quality	

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F 609	Continued From page 3 immediately reported the allegations to the state agency (SA). SW stated the allegation had not been submitted timely and should have been submitted within two hours of the incident. During an interview on 3/29/23 at 3:51 p.m. director of nursing (DON) stated she had not been aware of the allegations until she found the note from LPN-A in her facility mailbox on Monday morning 3/27/23. DON stated she was confused because the written report did not look like LPN-A's handwriting. DON stated she informed the SW and found that NA-A had worked Friday 3/24/23 and Sunday 3/26/23 and was suspended on Monday after she found the allegations. DON stated she interviewed LPN-A and was informed that NA-B had made the allegations to her on 3/25/23 but had not specified the resident. DON indicated the allegations should have been reported to the State Agency within two hours. Facility policy entitled, Chosen Valley Care Center Abuse Prevention Policies and Procedures, undated: under the Abuse investigation and reporting, defined immediately as soon as possible but no later than 2 hours from the time initial knowledge that the incident occurred has been received. Further review of policy indicates a mandated reporter who has reason to believe that a vulnerable adult is being or has been subjected to maltreatment/mistreatment shall immediately report the information to the director of social services or designee who will notify the director of nursing and administrator immediately. The licensed social worker or designee with the same authority will make and initial report of the incident or suspected incident to the state agency of health facility complaints, immediately in	F 609	Assurance Performance Improvement (QAPI) committee implemented an Abuse Prevention Performance Improvement Project (PIP) 4/3/2023. The goal of the PIP is to increase percentage of perfect Abuse Prevention test scores from 74% to 95% by July 1st, 2023. To monitor compliance, the Social Worker/Designee will initiate Abuse Prevention and Reporting tests. Tests will randomly be given to staff from all departments monthly for completion. Incorrect answers will be addressed by their Supervisor or designee. If any concerns are identified or noncompliance with related regulations and/or facility policies are noted during the monitoring process, additional auditing and staff training will be done. Abuse Prevention education has been added to the agenda of each quarterly All Staff Meetings for review and discussion. Upon hire during orientation, all staff will continue to be required to review the Abuse Prevention Policies and Procedures. They will also be given the Abuse Prevention and Reporting test to monitor understanding of the policy. Compliance will be reviewed during the April Quality Assurance Committee meeting and ongoing.	

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F 609	Continued From page 4 accordance with law. Under the Protection subtitle defined the mandated reported will be assured that there will be no retaliation or punishment against a person who reports maltreatment in good faith.	F 609		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 11, 2023

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

Re: Event ID: 3FIS11

Dear Administrator:

The above facility survey was completed on March 29, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@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 _____	03/29/2023

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CHOSEN VALLEY CARE CENTER	1102 LIBERTY STREET SOUTHEAST CHATFIELD, MN 55923

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/28/23 and 3/29/23, a standard abbreviated survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure The following complaints were reviewed with no	2 000		

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	00750	A. BUILDING: _____ B. WING _____	03/29/2023

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CHOSEN VALLEY CARE CENTER	1102 LIBERTY STREET SOUTHEAST CHATFIELD, MN 55923

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2 000	Continued From page 1 deficiency issued. H54239618C (MN00091999), H54239842C (MN00092284) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		