Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 2, 2022

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

RE: CCN: 245564
Cycle Start Date: September 28, 2022

Dear Administrator:

On October 26, 2022, we notified you a remedy was imposed. On November 16, 2022 the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 18, 2022.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 28, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of October 12, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 28, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on November 18, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered

December 2, 2022

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

Re: Reinspection Results
Event ID: 0JVQ12

Dear Administrator:

On November 22, 2022 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 October 18, 2022 . At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered

October 26, 2022

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

RE: CCN: 245564
Cycle Start Date: September 28, 2022

Dear Administrator:

On October 12, 2022, we informed you that we may impose enforcement remedies.

On October 18, 2022, the Minnesota Department(s) of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found 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.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 28, 2022

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 28, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 28, 2022.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is

your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by December 28, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Browns Valley Health Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 28, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

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 March 28, 2023 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Electronically delivered
October 26, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: 0JVQ11

Dear Administrator:

The above facility was surveyed on October 17, 2022 through October 18, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

the Suggested Method of Correction and the Time Period For Correction.

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

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

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

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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 ______	C 10/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNS VALLEY HEALTH CENTER	**114 JEFFERSON STREET SOUTH BROWNS VALLEY, MN 56219**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 10/17/22, to 10/18/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be UNSUBSTANIATED: H55645150C (MN 87489). The following complaint was found to be SUBSTANTIATED: H55645122C (MN87524), with a deficiency cited at 689. 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 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent	F 689		11/18/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 11/01/2022

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 ______	C 10/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNS VALLEY HEALTH CENTER	114 JEFFERSON STREET SOUTH BROWNS VALLEY, MN 56219

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F 689	Continued From page 1 accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff were following fall risk interventions implemented for 1 of 2 (R1) residents identified at risk for falls to prevent further falls. Findings include: R1's quarterly Minimum Data Set (MDS) dated 8/24/22, identified R1 had moderate impaired cognition and had diagnoses which included diabetes mellitus, non-Alzheimer's dementia, and depression. The MDS indicated R1 required extensive assistance from staff with toileting, transfers, and personal hygiene. R1's fall assessment dated 8/25/22, identified R1was at risk for falls due to impaired cognition, impaired vision and previous falls. R1's fall assessment indicated R1 was occasionally incontinent of bladder and required staff assistance with transfers. R1's fall investigation report dated 10/7/22, identified R1 had an unwitnessed fall at 5:00 a.m. The report indicated R1 was found sitting on her fall mat next to the bed, had no footwear on and R1's wheelchair was across the room. The report indicated R1 was sent to the emergency room (ER) for left hip pain. The report identified R1 received an Xray of her left hip which was inconclusive and a cat scan (CT) scan had been completed which indicated a fracture of the left hip. CT scan dated 10/7/22, indicated R1 sustained a	F 689	R1's care plan was reviewed and revised for fall risk interventions. Staff will be educated on current interventions, and new falls risk interventions that were added onto R1's care stream and care plan. This could happen to all residents that are at risk for falls. The residents that are at risk for falls will have their fall risk care plans/interventions reviewed and revised. Any changes that are made will be added to the residents care stream, placed in the communication book and communicated to staff at the change of shift. The DON or designee will review/revise the policies and procedures on fall risk and management. The DON or designee will educate staff on how changes to the resident's care will be communicated and where to find these changes on care stream. Education will also be provided on the importance of following the care plan and on the policy/procedure for falls. The DON or designee will conduct audits on fall interventions being followed and communication/knowledge of fall interventions. Audits will be done 3x/week for 4 weeks, 2x/week for 4 weeks, and 1 x/week for 4 weeks and then monthly thereafter. Findings will be brought to QAPI for further recommendation.	

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	245564	A. BUILDING ______ B. WING ______	C 10/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNS VALLEY HEALTH CENTER	114 JEFFERSON STREET SOUTH BROWNS VALLEY, MN 56219

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F 689	Continued From page 2	F 689		

left hip fracture.

R1's care plan dated 10/8/22, identified R1 was at risk for falls and required assistance from staff with mobility and transfers. R1's care plan indicated the call light should have been within reach. The care plan identified R1 was to wear gripper socks at all times, a bed sensor and arial silent floor sensor were to be in place and R1's wheelchair was to be placed next to the bed.

During an observation on 10/17/22, at 10:36 a.m. R1 was lying in her bed, fall mat was placed on the floor next to the bed and R1's wheelchair was noted to be across the room near the bathroom door.

During an observation on 10/17/22, at 11:10 a.m. nursing assistant (NA)-A was observed exiting R1's room. R1 was observed lying in bed on her left side and wheelchair was noted to be across the room near the entrance of the room.

During an observation on 10/17/22, at 1:18 p.m. NA-A placed a transfer belt on R1 and used the non mechanical lift to transfer R1 to the bathroom. R1 wiped herself after completing her toileting tasks and NA-A pulled up R1's pants. NA-A proceeded to assist R1 into bed using the non-mechanical lift to transfer her. NA-A washed her hands and placed R1's wheelchair across the room near the entrance of the room.

During an interview on 10/17/22, at 1:36 p.m. NA-A stated R1 required moderate assistance with her activities of daily living (ADL's). NA-A stated R1 had fallen twice. NA-A indicated she was aware of the fall interventions prior to R1's last fall however was not aware of any new

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 3	F 689		

interventions being implemented after R1's last fall on 10/7/22. NA-A confirmed she had placed the wheelchair near the entrance of the room.instead of next to R1's bed. NA-A stated she was unaware the wheelchair should have been placed next to R1's bed.

During an interview on 10/17/22, at 1:48 p.m. NA-B indicated R1 required moderate assistance from staff with transfers and toileting. NA-B stated R1 had fallen twice recently and had fractured her left hip during the last fall. NA-B stated the new fall interventions for R1 after the last fall was a toileting plan and to ensure R1 was wearing gripper socks. NA-B stated she was unaware R1's wheelchair should have been placed next to R1's bed.

During an interview on 10/17/22, at 2:55 p.m. licensed practical nurse (LPN)-A indicated R1 was at risk for falls and required extensive assistance with transferring and toileting. LPN-A stated R1 recently had two falls and had fractured her left hip during the last fall. LPN-A indicated after R1's last fall, a toileting plan had been implemented. LPN-A verified R1's care plan identified R1's wheelchair should have been placed next to R1's bed when R1 was in bed. LPN-A confirmed R1's wheelchair had been placed across the room near the entrance to her room and was not near R1's bed.

During an interview on 10/17/22, at 3:30 p.m. LPN-B stated she had been working the night when R1 fell and fractured her left hip. LPN-B stated on 10/7/22, at 5:00 a.m. R1 had been found sitting on her fall mat next to her bed and R1's wheelchair had been placed across the room near the entrance. LPN-B stated R1 had

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 ______	C 10/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNS VALLEY HEALTH CENTER	114 JEFFERSON STREET SOUTH BROWNS VALLEY, MN 56219

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F 689	Continued From page 4	F 689		

been attempting to use the bathroom when she fell. LPN-B indicated she assessed R1 at the time of the fall and R1 appeared to not have had any injuries. LPN-B stated R1complained of left hip later that same day and had been sent to the ER where she was diagnosed with a fractured left hip. LPN-B confirmed she implemented an immediate intervention of placing R1's wheelchair next to the bed when R1 was in bed. Additionally, LPN-B stated a trial toileting plan had been started for R1. LPN confirmed the new interventions had been placed in R1's care plan.

During an interview on 10/17/22, at 3:39 p.m. director of nursing (DON) verified R1 had fallen out of bed on 10/7/22, and sustained a left hip fracture. DON verified the immediate care planned interventions were to initiate a toileting plan, to decrease fluids after 9:00 p.m. and to ensure R1's wheelchair had been placed next to the bed when R1 was in bed. DON stated it was her expectation staff would have followed care planned interventions.

Review of a facility policy title Fall Prevention and Management revised 3/7/22, indicated a post fall assessment would have been done when the resident was residing in the care center. Policy indicated an immediate intervention would have been put into place and all interventions identified through the assessment would have been documented in the resident's care plan using person centered language.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00668	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 10/18/2022

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) COMPLETE DATE
2 000	Initial Comments	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 10/17/22, to 10/18/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00668	A. BUILDING: ______ B. WING ______	C 10/18/2022

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2 000	Continued From page 1 The following comlaint was found to be UNSUBSTANIATED: H5645150C (MN87489). The following complaint was found to be SUBSTANTIATED: H55645122C (MN87524), with a licensing order issued at 0830. 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 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 surveyor ' s 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 <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the	2 000		

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2 000	Continued From page 2 heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff were following fall risk interventions implemented for 1 of 2 (R1) residents identified at risk for falls to prevent further falls.	2 830	Corrected	11/18/22

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2 830	Continued From page 3	2 830		

Findings include:

R1's quarterly Minimum Data Set (MDS) dated 8/24/22, identified R1 had moderate impaired cognition and had diagnoses which included diabetes mellitus, non-Alzheimer's dementia, and depression. The MDS indicated R1 required extensive assistance from staff with toileting, transfers, and personal hygiene.

R1's fall assessment dated 8/25/22, identified R1was at risk for falls due to impaired cognition, impaired vision and previous falls. R1's fall assessment indicated R1 was occasionally incontinent of bladder and required staff assistance with transfers.

R1's fall investigation report dated 10/7/22, identified R1 had an unwitnessed fall at 5:00 a.m. The report indicated R1 was found sitting on her fall mat next to the bed, had no footwear on and R1's wheelchair was across the room. The report indicated R1 was sent to the emergency room (ER) for left hip pain. The report identified R1 received an Xray of her left hip which was inconclusive and a cat scan (CT) scan had been completed which indicated a fracture of the left hip.

CT scan dated 10/7/22, indicated R1 sustained a left hip fracture.

R1's care plan dated 10/8/22, identified R1 was at risk for falls and required assistance from staff with mobility and transfers. R1's care plan indicated the call light should have been within reach. The care plan identified R1 was to wear gripper socks at all times, a bed sensor and arial silent floor sensor were to be in place and R1's wheelchair was to be placed next to the bed.

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2 830	Continued From page 4 During an observation on 10/17/22, at 10:36 a.m. R1 was lying in her bed, fall mat was placed on the floor next to the bed and R1's wheelchair was noted to be across the room near the bathroom door. During an observation on 10/17/22, at 11:10 a.m. nursing assistant (NA)-A was observed exiting R1's room. R1 was observed lying in bed on her left side and wheelchair was noted to be across the room near the entrance of the room. During an observation on 10/17/22, at 1:18 p.m. NA-A placed a transfer belt on R1 and used the non mechanical lift to transfer R1 to the bathroom. R1 wiped herself after completing her toileting tasks and NA-A pulled up R1's pants. NA-A proceeded to assist R1 into bed using the non-mechanical lift to transfer her. NA-A washed her hands and placed R1's wheelchair across the room near the entrance of the room. During an interview on 10/17/22, at 1:36 p.m. NA-A stated R1 required moderate assistance with her activities of daily living (ADL's). NA-A stated R1 had fallen twice. NA-A indicated she was aware of the fall interventions prior to R1's last fall however was not aware of any new interventions being implemented after R1's last fall on 10/7/22. NA-A confirmed she had placed the wheelchair near the entrance of the room.instead of next to R1's bed. NA-A stated she was unaware the wheelchair should have been placed next to R1's bed. During an interview on 10/17/22, at 1:48 p.m. NA-B indicated R1 required moderate assistance from staff with transfers and toileting. NA-B stated R1 had fallen twice recently and had fractured her	2 830		

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2 830	Continued From page 5 left hip during the last fall. NA-B stated the new fall interventions for R1 after the last fall was a toileting plan and to ensure R1 was wearing gripper socks. NA-B stated she was unaware R1's wheelchair should have been placed next to R1's bed. During an interview on 10/17/22, at 2:55 p.m. licensed practical nurse (LPN)-A indicated R1 was at risk for falls and required extensive assistance with transferring and toileting. LPN-A stated R1 recently had two falls and had fractured her left hip during the last fall. LPN-A indicated after R1's last fall, a toileting plan had been implemented. LPN-A verified R1's care plan identified R1's wheelchair should have been placed next to R1's bed when R1 was in bed. LPN-A confirmed R1's wheelchair had been placed across the room near the entrance to her room and was not near R1's bed. During an interview on 10/17/22, at 3:30 p.m. LPN-B stated she had been working the night when R1 fell and fractured her left hip. LPN-B stated on 10/7/22, at 5:00 a.m. R1 had been found sitting on her fall mat next to her bed and R1's wheelchair had been placed across the room near the entrance. LPN-B stated R1 had been attempting to use the bathroom when she fell. LPN-B indicated she assessed R1 at the time of the fall and R1 appeared to not have had any injuries. LPN-B stated R1complained of left hip later that same day and had been sent to the ER where she was diagnosed with a fractured left hip. LPN-B confirmed she implemented an immediate intervention of placing R1's wheelchair next to the bed when R1 was in bed. Additionally, LPN-B stated a trial toileting plan had been started for R1. LPN confirmed the new interventions had been placed in R1's care plan.	2 830		

Minnesota Department of Health

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During an interview on 10/17/22, at 3:39 p.m. director of nursing (DON) verified R1 had fallen out of bed on 10/7/22, and sustained a left hip fracture. DON verified the immediate care planned interventions were to initiate a toileting plan, to decrease fluids after 9:00 p.m. and to ensure R1's wheelchair had been placed next to the bed when R1 was in bed. DON stated it was her expectation staff would have followed care planned interventions.

Review of a facility policy title Fall Prevention and Management revised 3/7/22, indicated a post fall assessment would have been done when the resident was residing in the care center. Policy indicated an immediate intervention would have been put into place and all interventions identified through the assessment would have been documented in the resident's care plan using person centered language.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review policies and procedures, train staff, and implement measures to prevent and/or minimize the risk for falls for residents at risk to assure they are receiving the necessary treatment/services. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented to better ensure implementation of treatment.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.