Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 24, 2024

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

RE: CCN: 245564
Cycle Start Date: April 17, 2024

Dear Administrator:

On April 17, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by July 17, 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 October 17, 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

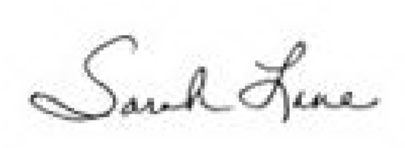
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

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

Feel free to contact me if you have questions.

Sincerely,



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 _____	04/17/2024

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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E 000	Initial Comments On 4/15/24 to 4/17/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1)	E 041		4/29/24

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

Electronically Signed | 04/30/2024

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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E 041	Continued From page 1 Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may	E 041		

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E 041	Continued From page 2 inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by:	E 041		

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E 041	Continued From page 3 Based on interview and document review, the facility failed to maintain standards for the emergency and standby power system. This deficient practice had the potential to affect all 27 residents residing in the facility. Findings Include: On 04/17/24 between 9:45 a.m. and 11:45 a.m., it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that a monthly generator inspection was completed during the month of March of 2024. During an interview on 4/17/24 at 2:50 p.m., the facility administrator verified these deficient findings at the time of discovery.	E 041	E041 Browns Valley Health Center intent is to ensure all residents have emergency power. All staff have been educated as of 04/29/2024 on importance of monthly generator and emergency power testing. Maintenace Director and/or designee will complete audits monthly to monitor completion of monthly generator and emergency power testing. Monthly audits will start as of 04/25/2024 and be conduct for 6 continuous months. Audits will in addition be reviewed for completion by Administrator. Audits will be reviewed at QAPI to provide further direction or additional auditing. Compliance as of 04/29/2024.	
F 000	INITIAL COMMENTS On 4/15/24 to 4/17/24, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to	F 000		

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F 000	Continued From page 4 validate substantial compliance with the regulations has been attained.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper wheelchair positioning was implemented for 1 of 1 residents (R4) observed to have concerns with positioning. In addition, the facility failed to comprehensively assess and implement interventions for 1 of 1 residents (R16) observed with edema (excess of watery fluid collection in tissues of body). Findings include: POSITIONING R4's annual Minimum Data Set (MDS) dated 2/8/24, identified R4 had severe cognitive impairment with diagnoses which included: dementia, arthritis, and low back pain. Indicated R4 used a wheelchair with substantial/maximal assistance to wheel 50 feet, and was dependent to wheel 150 feet.	F 684	F684 EDEMA Browns Valley Health Center intent is to ensure all residents are assess for edema weekly during the General Observation Assessment. R-16 was not assisted in putting on his knee-high stockings in the AM and had edema present in bilateral lower extremities. Immediately R-16 received, and an order was from PCP for compression stockings and fitted by OT, the compression stockings were ordered and received 4/26/24 placed on resident by therapy. Care Plan has been updated and tasks flow to ETAR and Care Stream. All residents have the potential to be affected and were assessed by RN for edema completed 4/26/24. A request for PCP's to address on their monthly rounds regarding edema and the use of compression stocking/hose completed on 4/26/24. All residents with compression	5/13/24

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F 684	Continued From page 5 R4's care plan dated 4/17/24, identified R4 required a Hoyer (mechanical) lift to transfer, a manual wheelchair with interventions that included: needed assistance with wheelchair, clear obstacles from pathway, and staff to propel from one destination to another. During an observation on 4/15/24 at 4:31 p.m., R4 was dressed in street clothes and seated in manual wheelchair in the Coliseum sitting area. R4 wore slipper socks and R4's feet dangled from the wheelchair seat, approximately five to six inches off the floor with her toes pointed down. R4's wheelchair had no foot pedals and R4's feet could not reach the floor. At 6:01 p.m., R4 was observed in her wheelchair in the Coliseum sitting area. R4's feet continued to dangle from the wheelchair seat, approximately two inches from the floor, while her toes pointed down towards the floor. At 7:46 p.m., R4 was observed in her wheelchair in the Coliseum sitting area, while her feet continued to dangle above the floor approximately two inches. During an observation on 4/16/24 at 11:52 a.m., R4 was dressed in street clothes seated in a manual wheelchair in the Coliseum sitting area. R4's stocking covered toes were observed to touch the floor by the tips of the toes, while the rest of R4's feet dangled off the floor. At 1:21 p.m., R4 was observed in the wheelchair in the Coliseum sitting area. R4's stocking covered feet were observed to dangle from the floor one to two inches above the floor. R4 began to propel herself slowly around the area in her wheelchair, using her hands on the wheels. During an interview on 4/16/24 at 2:40 p.m., nursing assistant (NA)-A stated R4 used her	F 684	stockings/hose have a doctor's order. The Care Plan has been updated and tasks flow to the ETAR and Care Stream. All staff meeting held on 4/29/24 to educate staff on the proper application/removal of compression stockings/hose, along with review of the policy. The DON/designee will complete audits on General Observations 1 x a week x 2 month to ensure edema is being documented, Audits for daily documentation of compression socks/hose and skin assessment documentation 3 x a week x 3 weeks, 2x a week x 2 weeks, then 1 x a week x 1 month. Audits will be reviewed at QAPI to provide further direction or additional auditing. Compliance as of 04/29/2024 POSITIONING Browns Valley Health Center intent is to ensure all residents are properly positioned in their w/c's. R4- wheelchair cushion was replaced immediately, R4's feet touch the ground and can propel self with tops of bilateral feet, unable to place feet flat as resident has contractures, family contacted for approval of OT screen for wheelchair positioning and permission granted by POA completed on 4/25/24. This could potentially happen to all residents. All residents that utilize a w/c will be screened by BST for proper w/c positioning by 5/13/24. BST OT completes quarterly assessments; the assessment tool has been updated to document the completion of w/c positioning concerns or	

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F 684	Continued From page 6 hands to propel her wheelchair however it went slowly. NA-A indicated R4 had never used wheelchair pedals and felt R4's feet would not sit flat on the floor. NA-A indicated she was not aware if R4 had ever been assessed for wheelchair positioning. During an interview on 4/16/24 at 3:56 p.m., licensed practical nurse (LPN)-C stated R4 required a Hoyer for transferring and used a wheelchair for mobility. LPN-C confirmed R4's feet dangled from the wheelchair above the floor, and indicated R4 used the tips of her toes while propelling the wheelchair and did not use foot pedals on her wheelchair. LPN was unsure if R4 had been assessed for wheelchair positioning by therapy and stated R4 had not had a therapy evaluation recently. LPN-C stated it was important for R4's feet to be supported in her wheelchair for good positioning. During an observation on 4/17/24 at 7:14 a.m., R4 was dressed in street clothes seated in her wheelchair, R4's right foot dangled above the floor, while R4's left toes were touching the floor. At 12:47 p.m., R4 was in wheelchair at table in the dining room. R4's left toes were touching the floor by the tips, while R4's right toes rested on the bottom of the table stand. During an interview on 4/17/24 at 1:03 p.m., certified occupational therapist assistant (COTA)-A confirmed COTA-A had worked with R4 previously related to her shoulder however it had been over a year ago. COTA-A stated for wheelchair assessments, they looked for proper fit, sitting balance, posture, safety and mobility. COTA-A stated R4 did not use foot pedals due to contractions in both knees and ankles and	F 684	no concerns along with documentation how the concern was addressed. BST will return assessment to MDS/Restorative Therapy Director for review. All staff Mandatory Meeting held on 4/29/24 with Big Stone Therapy on w/c positioning, review of updated Therapy Screen and Evaluation form for concerns, and policy. The DON/ Designee will complete audits 2x a week for 3 weeks, 1 x a week for 3 weeks and then visit at monthly QAPI meetings to provide direction and additional auditing. Compliance as of 05/13/2024	

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F 684	Continued From page 7 confirmed R4's feet barely touched the floor. COTA-A indicated when a resident's feet dangled above the floor, staff just needed to ensure the resident was safe and it did not cause pressure on their legs. COTA-A indicated improper positioning could cause discomfort for the resident. COTA-A stated COTA-A had never observed R4 propel herself in her wheelchair using her feet, just her arms. COTA-A stated they could do an assessment for a different wheelchair for R4, as R4's wheelchair could not be lowered. EDEMA R16 R16's significant change MDS dated 3/6/24, identified R16 was cognitively intact and had diagnoses which included: heart failure, hypertension, chronic kidney disease and diabetes mellitus. Identified R16 was dependent on staff assistance for dressing and putting on/taking off footwear. R16's care plan dated 4/17/24, identified R16 was at risk for shortness of breath, edema or chest pain related to congestive heart failure. Interventions included to monitor for signs and symptoms of heart failure, which included edema. Indicated R16 required assistance with dressing, with interventions which included assist of one with putting on knee high socks in morning (AM) and removing at bed time (HS). To do while in bed or recliner. R16's Weekly General Observation Results assessments reviewed form 1/18/24 to 4/12/24, identified the following: -1/18/24-pedal edema (swelling from fluid	F 684		

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F 684	Continued From page 8 gathered in feet and lower legs) present -yes, right lower extremity, edema-2+ (numbered pitting edema scale which identified indentation and depth, with rebound time, scale of 1-4), left lower extremity edema-2+. -1/24/24-pedal edema present-yes, right lower extremity edema-2+, left lower extremity edema-2+. -2/7/24, area blank related to edema, not assessed. -2/14/24-pedal edema present-yes, bilateral extremities-3+. -2/21/24-area blank related to edema, not assessed. -3/14/24-pedal edema present-yes, bilateral extremities-3+. -3/20/24-area blank related to edema, not assessed. -3/29/24- pedal edema present-yes, right lower extremity edema-2+, left lower extremity edema-2+. -4/12/24-pedal edema present-yes, right lower extremity edema-1+, left lower extremity edema-1+. R16's progress notes reviewed from 1/23/24 to 4/17/24, identified on 2/25/24, R16 was admitted to hospital related to decline in health condition with CHF and renal failure. R16's primary care physician (PCP)-A's progress note dated 4/9/24, identified R16 had recovered from the serious illness he had. Progress note identified extremities had no clubbing (enlargement of ends) or cyanosis (bluish discoloration). R16's progress note lacked information if R16 had edema present or there was treatment for R16's edema.	F 684		

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	245564	A. BUILDING _____ B. WING _____	04/17/2024

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F 684	Continued From page 9 During an interview on 4/15/24 at 2:06 p.m., R16 stated he did have edema and swelling. R16 indicated the staff did not want to apply his stockings any more as they were tight and too small. R16 stated he liked to wear them, however was unable to get to town to purchase new ones. R16 was wearing regular black socks, and no compression stockings during observation, and his feet and ankles appeared slightly swollen. During an observation and interview on 4/16/24 at 11:18 a.m., R16 was in the common area seated in his wheelchair participating in exercise activity. R16 wore sandals with regular black socks. At 1:29 p.m., R16 was in his room in his wheelchair reading. R16 stated he did have some swelling of his feet and ankles today. R16's feet appeared to have some indentation where the sandal straps were across the tops of his feet. R16 stated he did not wear his shoes since they were too tight and they were stored on a small shelf on a table next to his chair. During an interview on 4/16/24 at 2:53 p.m., NA-A stated night staff assisted him with dressing in the morning since he usually woke up around 4 a.m. NA-A stated R16 did not ask for his knee high socks any more and was not certain why. During an interview on 4/16/24 at 4:19 p.m., LPN-C stated R16 wore compression stockings and the night shift usually applied them. LPN-C indicated the stockings were important to help with edema and circulation. LPN-C stated it would have been identified on R16's care guide (care plan) for the nursing assistants or the treatment administration record (TAR) if the nurses were to apply the compression stockings.	F 684		

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F 684	Continued From page 10 LPN-C stated it might have been on the night shifts TAR. At 4:32 p.m., LPN-C confirmed R16 did not have compression stockings on and confirmed R16 had 3+ edema of his feet and ankles. During an interview on 4/17/24 at 1:14 p.m., director of nursing (DON) confirmed residents feet should not dangle above the floor while in wheelchairs. DON indicated she became aware of the concern with R4's wheelchair positioning yesterday and stated they noticed R4 had a different wheelchair cushion in her wheelchair. They placed R4's old cushion back in her wheelchair yesterday and thought that was helpful. DON indicated the facility's usual process was to have therapy assess residents for proper fitting wheelchairs. DON stated it was important to have proper fitting wheelchairs to prevent injury. DON confirmed R4's feet dangled off the floor and indicated it could cause R4 pain and R4 did not have any where to rest her feet. During an interview on 4/16/24 at 4:52 p.m., director of nursing (DON) confirmed R16 had never had an order for compression stockings. DON confirmed R16 had 2-3+ edema now. DON indicated it would have been helpful for R16 to wear compression stockings to decrease swelling. DON stated she had assisted to apply R16's knee high stockings on, however it was not easy to apply them. DON stated she would have to discuss with PCP-A to obtain an order for them. DON stated R16 had a type of compression knee high stockings in his drawer. At 5:27 p.m., DON stated she contacted PCP-A, and indicated PCP-A was not aware R16 wore compression stockings, and wanted R16 measured for Job stockings by therapy. DON	F 684		

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F 684	Continued From page 11 stated she would have expected the nurses to notify PCP-A that R16 had edema and was wearing compression stockings. DON stated it was important to obtain R16's measurements for correct fit for R16's edema. DON indicated she was not sure if any nursing staff were aware R16's knee high stockings were actually compression stockings. On 4/17/23 at 10:31 a.m., DON indicated she had contacted R16's family member and was informed R16 purchased those stockings over the counter himself. On 4/17/24 at 11:53 a.m., a phone call and message was left to PCP-A for interview. No return call was received. The facility policy titled Adaptive And Positioning Equipment dated 11/2023, identified the facility would provide equipment that allowed residents to achieve their highest most practicable level of function. The policy procedure identified nursing would make referral to occupational therapy (OT) or physical therapy (PT) for wheelchair positioning, seating assessment or other adaptive equipment recommendation. OT/PT staff would conduct the assessment and make a recommendation for wheelchair modification and/or equipment. Nurse manager documented equipment use in care plan. Nursing and/or OT department (dept.) observed appropriateness of continued use of equipment. The facility policy titled Application & Removal Of Compression Stockings/Support Hose dated 1/2014, identified application and removal of compression stockings/support hose was done in accordance with the physician's plan of care. Continuous assessment/monitoring of the lower extremities should always accompany the	F 684		

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F 684	Continued From page 12 changing of compression stockings/support hose. This included swelling, color changes, temperature changes, presence of pain, areas of constriction, or skin abrasions. The policy procedure included to check the care plan for any specific client instructions.	F 684		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed	F 851		4/17/24

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F 851	Continued From page 13 practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to submit complete and accurate direct care staffing information, including information for licensed practical nursing staff, based on payroll and other verifiable and auditable data, during 1 of 1 quarters reviewed (Quarter 1), to the Centers for Medicare and Medicaid Services (CMS) according to specifications established by CMS. This deficient	F 851	F851 Browns Valley Health Center intent is to ensure all staffing hours are submitted and accurate to MDH/CMS through PBJ. Individuals that submit PBJ have been educated as of 04/17/2024 on the correct and accurate submissions of PBJ to MDH/CMS. Browns Valley Health Center will work in conjunction with our	

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F 851	Continued From page 14 practice had the potential to affect all 27 residents residing in the facility. Findings include: Review of the Payroll Based Journal Report (PBJ) Casper Report 1705 D identified the following dates triggered for review: 10/01/23, 10/03/23, 10/07/23, 10/08/23,1 0/10/23, 10/12/23, 10/14/23, 10/15/23, 10/17/23, 10/21/23, 10/22/23, 10/23/23, 10/26/23, 10/28/23, 10/29/23, 10/31/23, 11/04/23, 11/05/23, 11/10/23, 11/11/23, 11/12/23, 11/14/23, 11/17/23, 11/18/23, 11/19/23, 11/21/23, 12/02/23, 12/03/23, 12/09/23, 12/10/23, 12/12/23, 12/19/23, 12/23/23, 12/24/23, 12/29/23, 12/30/23, and 12/31/23, for failure to have licensed nurse coverage 24 hours per day. Review of staffing schedules from 10/1/23 thorough 12/31/23, identified the facility had ten staff identified to have worked: registered nurse (RN)-A, RN-B, RN-C, Licensed Practical Nurse (LPN)-A, LPN-B, LPN-C, LPN-D, LPN-E, director of nursing (DON) and assistant director of nursing (ADON) on each of the above dates listed. In addition, review of staff's time cards from 10/1/23 through 12/31/23, on the above-mentioned dates identified licensed nursing staff had worked. Review of the facility's staffing schedules and time cards identified a discrepancy with the PBJ report. During an interview on 4/15/24 at 6:20 p.m., administrator confirmed the above findings and stated licensed staff had worked on the dates mentioned above. In addition, administrator indicated the PBJ report was inaccurate and was aware of the issues. Administrator stated the LPN	F 851	employment systems associates to ensure compliant practices are occurring and accurate reports are being submitted through CMS. Administrator will audit PBJ hours prior to submission each quarter. Audits will be reviewed at QAPI to provide further direction or additional auditing. Compliance as of 04/17/2024.	

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F 851	Continued From page 15 staff and trained medication aides (TMAs) were not coded correctly, and the facility knew how to fix the issues going forward. Review of the facility policy titled Payroll Based Journal (PBJ) dated 4/1/19, identified PBJ was CMS's mandatory electronic submission for long-term care of each care center's staffing information based on payroll data. The facility would use PBJ data to assure the delivery of quality of care to assure compliance with regulatory requirements. The policy identified the facility would gather complete and accurate direct care staffing information and the facility's Employment System Department (ESD) would review all PBJ data for accuracy and submit prior to the CMS mandated deadline.	F 851		

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/17/2024. At the time of this survey, Browns Valley Health Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99 Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K	K 000		

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

Electronically Signed | 04/30/2024

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

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K 000	Continued From page 1 TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Browns Valley Health Care is a 1-story building with a partial basement constructed at 2 different times. The original building was constructed in 1970 and was determined to be of Type II(111) construction. In 2001 an addition was added to the north that was determined to be of Type II(111)	K 000		

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K 000	Continued From page 2 construction. Because the original building and the addition are of the same type of construction, meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinkler protected and the sprinkler system, and has a fire alarm system with corridor smoke detection and smoke detection in spaces open to the corridors. The fire alarm system is monitored for automatic fire department notification. The facility has a capacity of 35 beds and had a census of 27 on the day of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET.	K 000		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to maintain exit signs per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.10.1, 7.10.5.1, and 7.10.5.2.1. This deficient finding could have an isolated impact on the	K 293	0293 □ An electrician has been contacted on 4/30/24 regarding the exit sign in the laundry room, it will be powered and lit by 05/17/24. Results will be shared at QAPI meetings	5/17/24

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K 293	Continued From page 3 residents within the facility. Findings include: On 04/17/2024 between 9:45 and 11:45 AM, it was revealed by observation that the emergency exit sign located next to the exit door in the basement laundry room was not illuminated. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 293		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324		5/17/24

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K 324	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to install proper protection for cooking equipment per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5.1, 19.3.2.5.3 (9). This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 04/17/2024 between 9:45 and 11:45 AM, it was revealed by observation that a stove in the North Kitchenette did not have a timer, not exceeding 120 minutes, that automatically deactivates the cooktop or range, independent of staff action. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 324	Electrician was contacted on 4/30/24 and will install automatic shut off timer to stove/range outlet to be completed by 05/17/24. Until then the stove/cooktop will be disconnected from service. Results will be shared at QAPI meetings.	
K 345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test battery operated smoke alarms per NFPA 101 (2012	K 345	Battery operated smoke detectors, will be tested monthly an form has been created on 4/30/24 for that purpose. Results will be	4/30/24

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	245564	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/17/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 345	Continued From page 5 edition), Life Safety Code, section 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 14.4.5. This deficient finding could have a widespread impact on residents within the facility. Findings include: On 04/17/2024 between 9:45 and 11:45 AM, it was revealed by a review of available documentation that single station battery operated smoke alarms were not being tested on a monthly basis. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 345	shared at QAPI meetings.	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25	K 353		4/30/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245564	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/17/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 353	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.1.1.1. This deficient finding could have an isolated impact on residents within the facility. Findings include: On 04/17/2024 between 9:45 and 11:45 AM it was revealed by observation that there was a build-up of dust and lint on a sprinkler head located by Room 167 Clean and Soiled Utility Rooms. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 353	Dusty sprinkler head in clean linen area, has been cleaned on 4/30/24 and all heads will be inspected quarterly. A form has been created on 4/30/24 for that purpose. Results will be shared at QAPI meetings.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 4, 2024

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

RE: CCN: 245564
Cycle Start Date: April 17, 2024

Dear Administrator:

On May 15, 2024, the Minnesota Departments of Health and Public Safety, 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