

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered April 20, 2022

Administrator Augustana HCC Of Apple Valley 14650 Garrett Avenue Apple Valley, MN 55124

RE: CCN: 245264

Cycle Start Date: March 31, 2022

Dear Administrator:

On March 31, 2022, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.
- 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 July 1, 2022.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 1, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 1, 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:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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 July 1, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Augustana Hcc Of Apple Valley will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 1, 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:

Pete Cole, RN Unit Supervisor Metro Team C District Office Licensing and Certification Program **Health Regulation Division** Minnesota Department of Health 85 East Seventh Place, Suite 220 P.O. Box 64900 Saint Paul, Minnesota 55164-0900 Email: peter.cole@state.mn.us

Office/Mobile: (651) 249-1724

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 September 30, 2022 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.

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:

William Abderhalden, Fire Safety Supervisor Deputy State Fire Marshal Health Care/Corrections Supervisor – Interim Minnesota Department of Public Safety 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145

Cell: (507) 361-6204

Email: william.abderhalden@state.mn.us

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kumalu Fishe Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

	OF ISOLATED DEFICIENCIES WHICH CAUSE	PROVIDER#	MULTIPLE CONSTRUCTION	DATE SURVEY						
NO HARM W	ITH ONLY A POTENTIAL FOR MINIMAL HARM		A. BUILDING:	COMPLETE:						
FOR SNFs AN	ID NFs	245264	B. WING	3/31/2022						
NAME OF PR	OVIDER OR SUPPLIER	STREET ADDRESS,	CITY, STATE, ZIP CODE							
AUGUSTA	NA HCC OF APPLE VALLEY	14650 GARRET APPLE VALLE								
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIEN	NCIES								
F 550	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)									
	§483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.									
	§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.									
	condition, or payment source. A facility	vide equal access to quality care regardless of diagnosis, severity of ility must establish and maintain identical policies and practices are provision of services under the State plan for all residents regardless of								
	§483.10(b) Exercise of Rights. The resident has the right to exercise hi of the United States.	his or her rights as a resident of the facility and as a citizen or resident								
		§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.								
	from the facility in exercising his or her rights as required under this subpart. This REQUIREMENT is not met as ex Based on observation, interview, and do	document review, the facility failed to provide a dignified dining who voiced they we being served meals with plastic dishware and								
	Findings include:	Findings include:								
	R43's quarterly Minimum Data Set (MI and required set-up support for eating.	(MDS), dated 1/26/22, identified R43 had moderate cognitive impairment ng.								
	he did not feel the facility staff treated I meals in his room on plastic on Styrofo R43 stated he would then have to ask st expressed being served on these plastic	On 3/28/22 at 6:51 p.m., R43 was seated in his room waiting for the supper meal to be served. R43 explained he did not feel the facility staff treated him with respect and dignity as he was repeatedly being served his meals in his room on plastic on Styrofoam dishware with plastic cutlery which had been happening "awhile." R43 stated he would then have to ask staff for "real silverware" but would only sometimes receive it and expressed being served on these plastic items made him feel "like I'm a baby." However, during this interview R43 was served his supper meal tray with ceramic plates and metallic silverware being provided.								

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

The above isolated deficiencies pose no actual harm to the residents

031099

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE		PROVIDER#	MULTIPLE CONSTRUCTION	DATE SURVEY
NO HARM WITH	HONLY A POTENTIAL FOR MINIMAL HARM		A. BUILDING:	COMPLETE:
FOR SNFs AND	NFs	245264	B. WING	3/31/2022
	TIDER OR SUPPLIER A HCC OF APPLE VALLEY	STREET ADDRESS, 14650 GARRET APPLE VALLE		•
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIES	NCIES		
F 550	Continued From Page 1			
	When interviewed on 3/30/22 at 9:45 a and explained she had noticed meals or "sometimes on plastic [dishware]." NA rather "everyone gets it," and she was u last observed plastic dishware and uten however, then the survey team entered now being served on and with regular or plastic dishware and added, "[R43] tell. On 3/30/22 at 10:42 a.m., the certified kitchen was using Styrofoam or plastic labor burden to use disposable items, as when the survey team entered on 3/28/2. To Staffing Shortage listing, dated 2/1/2 disposable items were used to serve me 2/12/22, 2/13/22, 2/14/22, 2/15/22, 2/1 3/2/22, 3/13/22, 3/18/22, 3/19/22, 3/20. When interviewed on 3/30/22 at 11:02 plastic or Styrofoam dishware being us RN-D stated she could not recall if R43 dishware and cutlery for meals "should A facility' policy on homelike and/or dishware and cutlery for meals "should a facility policy on homelike and/or dishware and cutlery for meals "should a facility policy on homelike and/or dishware and cutlery for meals "should a facility policy on homelike and/or dishware and cutlery for meals "should a facility policy on homelike and/or dishware and cutlery for meals "should a facility policy on homelike and/or dishware and cutlery for meals "should a facility policy on homelike and/or dishware and cutlery for meals "should a facility policy on homelike and/or dishware and cutlery for meals "should a facility policy on homelike and/or dishware and cutlery for meals "should a facility policy on homelike and/or dishware and cutlery for meals "should a facility policy on homelike and/or dishware and cutlery for meals "should a facility policy on homelike and/or dishware and cutlery for meals "should a facility policy on homelike and/or dishware and cutlery for meals "should a facility policy on homelike and/or dishware and cutlery for meals "should a facility policy on homelike and/or dishware and cutlery facility and the facility of the facility and	a the unit were serve.—B stated it was not insure why meals verified by used on Morand she had not seed ishware. Further, It is me he doesn't like dietary manager (C dishware and cutled and she verified they 22. A correspondir 22 to 3/29/22, was eals to the residents 8/22, 2/19/22, 2/20/22, 3/21/22/22/22/22/22/22/22/22/22/22/22/22/	ed using "sometimes on hard plates" as just R43's meals which were served of yere being served in such manner. NA inday morning (3/28/22) for the breakfight them used again since, instead all mNA-B stated R43 had expressed he dise those." DM) was interviewed. The CDM explory when they were short staffed as it may switched to ceramic dishware and may Dates That Paper Disposables Were provided which outlined each date plan. These dates included: 2/1/22, 2/6/22, 2/25/22, 2/26/22, 2/27/22, 2/28/22, and 3/29/22, totaling 23 out of 57 case unit manager (RN)-D stated she havely" on the unit for meals and was "no incerns with this directly to her but expedit to promote a homelike dining expedit	and on plastic but -B stated she fast meal, neals were sliked using lained the reduced the etal cutlery b Used Due astic and/or c, 2/11/22, 2, 3/1/22, days. ad seen of sure why." pressed

PRINTED: 04/20/2022 FORM APPROVED OMB NO. 0938-0391

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245264	B. WING	_		03/	31/2022
	PROVIDER OR SUPPLIER ANA HCC OF APPLE	VALLEY		1	TREET ADDRESS, CITY, STATE, ZIP CODE 4650 GARRETT AVENUE APPLE VALLEY, MN 55124		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	Initial Comments		ΕC	000			
E 004 SS=C	with Appendix Z, Er Requirements for L §483.73(b)(6) was recertification surve compliance. The facility's plan of as your allegation of Department's accepanceled in ePOC, yat the bottom of the form. Upon receipt of an onsite revisit of your validate substantial regulation has been Develop EP Plan, FCFR(s): 483.73(a) §403.748(a), §416. §441.184(a), §460. §483.475(a), §484. §485.625(a), §485. §486.360(a), §491. The [facility] must of Federal, State and preparedness requirements of this preparedness proglimited to, the follow	Review and Update Annually 54(a), §418.113(a), 84(a), §482.15(a), §483.73(a), 102(a), §485.68(a), 727(a), §485.920(a), 12(a), §494.62(a). comply with all applicable local emergency irements. The [facility] must and maintain a comprehensive edness program that meets the s section. The emergency ram must include, but not be	ΕC	004			
LABORATOR)	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	L NATURE		TITLE		(X6) DATE

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION		E SURVEY PLETED
		245264	B. WING			03/	31/2022
	PROVIDER OR SUPPLIER	VALLEY		1	STREET ADDRESS, CITY, STATE, ZIP CODE 4650 GARRETT AVENUE APPLE VALLEY, MN 55124		
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E 004	and maintain an em that must be [reviewevery 2 years. The following: * [For hospitals at § §485.625(a):] Emer CAH] must comply State, and local em requirements. The develop and maintain emergency prepare requirements of this all-hazards approach. * [For LTC Facilities Plan. The LTC facilian emergency prepreviewed, and updated and the emergency prepare reviewed, and updated and updated the emergency prepared the emergency pre	rergency preparedness plan wed], and updated at least plan must do all of the 482.15 and CAHs at regency Plan. The [hospital or with all applicable Federal, ergency preparedness [hospital or CAH] must ain a comprehensive edness program that meets the s section, utilizing an	E	004			
	by: Based on interview facility failed to revi- (EAP) annually in a requirements of CF	v and document review the ew the Emergency Action Plan ccordance with the TR 483.73. This had the II 122 residents currently					
	Findings include:						
	Review of the facilit	ty EAP lacked a signature					

AND DUAN OF CORRECTION TO THE CATION NUMBER.		` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245264	B. WING			03/	31/2022
	PROVIDER OR SUPPLIER	VALLEY		14	TREET ADDRESS, CITY, STATE, ZIP CODE 4650 GARRETT AVENUE PPLE VALLEY, MN 55124		
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E 004	the previous year. F provided to indicate by the Quality Assu	ge 2 ation it had been reviewed in Further, no documentation was the EAP had been reviewed rance and Performance I) committee in the previous	Ε(004			
E 013 SS=C	administrator verifice documentation to in reviewed the previous Development of EP	on 3/31/22, at 10:04 a.m. the ed he was unable to provide adicate the EAP had been ous year. Policies and Procedures	ΕŒ	013			
	§483.475(b), §484.	84(b), §482.15(b), §483.73(b), 102(b), §485.68(b), 727(b), §485.920(b),					
	develop and implent policies and proceed plan set forth in parassessment at para and the communication. The policies are processed in the policies and the	cedures. [Facilities] must ment emergency preparedness ures, based on the emergency agraph (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of olicies and procedures must adated at least every 2 years.					
	procedures. The LT implement emerger procedures, based forth in paragraph (assessment at para and the communicathis section. The position of the procedures are the communication of the procedures are the procedures.	at §483.73(b):] Policies and C facility must develop and ncy preparedness policies and on the emergency plan set a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of olicies and procedures must odated at least annually.					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				3) DATE SURVEY COMPLETED	
		245264	B. WING _		03/	31/2022	
	PROVIDER OR SUPPLIER	VALLEY		STREET ADDRESS, CITY, STATE, ZIP COD 14650 GARRETT AVENUE APPLE VALLEY, MN 55124			
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E 013		-	E 01	13			
	Facilities:	ments for PACE and ESRD					
	procedures. The P develop and implent policies and proced plan set forth in part assessment at part and the communicat this section. The part address management emergencies, include equipment, power, emergencies; and returned the health staff, or the public.	ACE organization must ment emergency preparedness ures, based on the emergency agraph (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of olicies and procedures must ent of medical and nonmedical ding, but not limited to: Fire; or water failure; care-related natural disasters likely to or safety of the participants, The policies and procedures and updated at least every 2					
	procedures. The di and implement eme and procedures, ba set forth in paragra assessment at para and the communica this section. The po be reviewed and up These emergencies to, fire, equipment of emergencies, water natural disasters like geographic area. This REQUIREMEN by: Based on document	es at §494.62(b):] Policies and alysis facility must develop ergency preparedness policies sed on the emergency plan oh (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of olicies and procedures must odated at least every 2 years. Is include, but are not limited or power failures, care-related or supply interruption, and ely to occur in the facility's					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED		
		245264	B. WING			03/	31/2022
	PROVIDER OR SUPPLIER	VALLEY		1	STREET ADDRESS, CITY, STATE, ZIP CODE 4650 GARRETT AVENUE APPLE VALLEY, MN 55124		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPORTION OF T	BE	(X5) COMPLETION DATE
E 013	implement policies under CFR 483.73, volunteers in an em during an emergent failed to ensure em procedures were reannually. This had to residents, as well a worked in the facility. Findings include: Review of the facility dated 2/26/20, indicor revised annually, the likelihood of a plikely (2) on a scale. Review of the follow they were not review-Emergency Water November 2019Electrical Power O-Disruption of Servity-Food and Nutrition Preparedness date-Internal Disaster P-Sheltering in Place. During an interview administrator stated not been reviewed a pandemic should instead of a 2 (mod also unable to provithe listed policies a reviewed or revised.	and procedures required to include: the use of hergency and tracking staff cy. In addition, the facility ergency policies and eviewed and/or revised the potential to affect all 122 s all staff and volunteers who y. The assessment indicated andemic was a moderately of 0 to 3. The assessment indicated wad or revised annually: Supply and Use dated The additional Use dated The ad		013			
SS=C		g	`				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245264	B. WING			03/	31/2022
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E 018	CFR(s): 483.73(b)(2) §403.748(b)(2), §442 and (v), §441.184(b) §482.15(b)(2), §483 §485.625(b)(2), §483 §494.62(b)(1). [(b) Policies and proceded planset forth in parassessment at parasent at paras	16.54(b)(1), §418.113(b)(6)(ii) 10(2), §460.84(b)(2), 13.73(b)(2), §483.475(b)(2), 13.920(b)(1), §486.360(b)(1), 15.920(b)(1), §486.360(b)(1), 16.54(b)(2), §483.475(b)(2), 17.920(c)(1), §486.360(c)(1), 18.920(c)(1),	E	018			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		ATE SURVEY DMPLETED	
		245264	B. WING _		03/	31/2022	
	PROVIDER OR SUPPLIER TANA HCC OF APPLE	VALLEY		STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
E 018	Policies and proced (ii) Safe evacuation includes considerat needs of evacuees; transportation; iden location(s) and princommunication with assistance. (v) A system to tracemployees' on-duty hospice's care during on-duty employees relocated during the must document the the receiving facility *[For CMHCs at §4] procedures. (2) Saf which includes constreatment needs of responsibilities; trar evacuation location means of communi assistance. *[For OPOs at § 48 procedures. (2) A sy documentation that donor information, p potential and actual secures and mainta *[For ESRD at § 49 procedures. (2) Saf	pice at §418.113(b)(6):] dures. from the hospice, which ion of care and treatment is staff responsibilities; tification of evacuation hary and alternate means of hexternal sources of k the location of hospice and sheltered patients in the hig an emergency. If the or sheltered patients are elemergency, the hospice specific name and location of or or other location. 85.920(b):] Policies and fe evacuation from the CMHC, sideration of care and evacuees; staff hisportation; identification of (s); and primary and alternate cation with external sources of 6.360(b):] Policies and yestem of medical preserves potential and actual protects confidentiality of I donor information, and hins the availability of records. 4.62(b):] Policies and fe evacuation from the dialysis des staff responsibilities, and	E 0 ²				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245264	B. WING		03/3	31/2022
	PROVIDER OR SUPPLIER	VALLEY		STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
E 018	This REQUIREMENT by: Based on interview facility failed to deve emergency prepare procedures that inconduty staff during emergency, this har residents currently staff. Findings include: Review of the facility Program did not incompared the facility full-scale drill held of the facility full	AT is not met as evidenced and document review, the elop and implement edness policies and luded a system to track evacuation in the case of and the potential to affect all 122 residing the facility as well as elude a policy or procedure to fon-duty staff that would during an emergency. The Evacuation Plan for the en 3/24/22, indicated all defrom the facility would be esignated staff to a designated tion. The plan also indicated a ck resident locations owever, the plan lacked	EO	18		
E 024 SS=C	administrator confir process in place to whereabouts during the facility. Policies/Procedures CFR(s): 483.73(b)(6) §403.748(b)(6), §4641.184(b)(6), §465	on 3/31/22, at 10:04 a.m. the med the facility did not have a track on-duty staff and their g an emergent evacuation of s-Volunteers and Staffing 6) 16.54(b)(5), §418.113(b)(4), 60.84(b)(7), §482.15(b)(6), 3.475(b)(6), §484.102(b)(5),	E 0	24		
	3.55 5(5)(6), 3100	5(2/(5), 3 15 1.152(5)(5),				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		245264	B. WING	·		03/	31/2022
	PROVIDER OR SUPPLIER TANA HCC OF APPLE	VALLEY		14	REET ADDRESS, CITY, STATE, ZIP CODE 650 GARRETT AVENUE PPLE VALLEY, MN 55124	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
E 024	§485.68(b)(4), §485.§485.920(b)(5), §485.920(b)(5), §485.920(b)(5), §485.920(b)(5), §485.920(b)(5), §485.920(b)(5), §485.920(b)(5), §485.920(b)(5), §485.920(b)(5), §485.920(c)(5), §485.920(c)(6) Policies and procedures and the communication of LTC far policies and procedures and procedures and procedures and procedures and proceduring strategies, if or integration of Standard and the care professeduring an emergency and oth strategies to addressed emergency. *[For Hospice at §44 procedures. (4) The an emergency and strategies, including integration of State health care professioneeds during an emergency and strategies, including integration of State health care professioneeds during an emergency.	5.625(b)(6), §485.727(b)(4), §1.12(b)(4), §494.62(b)(5). Decedures. The [facilities] must ment emergency preparedness lures, based on the emergency ragraph (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of policies and procedures must odated at least every 2 years acilities]. At a minimum, the lures must address the considered and Federally designated ionals to address surge needs every 2 years acilities and Federally designated ionals to address surge needs every and the surge of volunteers in an er emergency staffing as surge needs during an and the surge of hospice employees in other emergency staffing the process and role for and Federally designated sionals to address surge		024			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245264	B. WING			03/	31/2022
	PROVIDER OR SUPPLIER ANA HCC OF APPLE	VALLEY		14	REET ADDRESS, CITY, STATE, ZIP CODE 650 GARRETT AVENUE PPLE VALLEY, MN 55124		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
E 024 E 041 SS=C	volunteers in an emand role for integral designated health of surge needs during potential to affect at the facility. Findings include: During review of the procedures did not in an emergency, of strategies that utilized surge needs in an emand of the policy or procedure and use of voluntees of the use of voluntees other emergency state use of voluntees of the use of voluntees of voluntees of the use of voluntees of the use of voluntees of the use of voluntees of voluntees of the use of voluntees	(EPP) addressed the use of hergency including the process tion of State and Federally care professionals to address an emergency. This had the ll 122 residents who resided in le facility EPP, the policies and include the use of volunteers of other emergency staffing ed volunteers to address emergency. 3/31/22, at 10:04 a.m. the lattent addressed the training of ers during an emergency or affing strategies that involved ors. TC Emergency Power on for Participation: standby power systems. The ement emergency and standby ed on the emergency plan set a) of this section and in the lures plan set forth in and (ii) of this section.		024			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		E SURVEY PLETED
		245264	B. WING			03/	31/2022
	PROVIDER OR SUPPLIER	VALLEY		1465	EET ADDRESS, CITY, STATE, ZIP CODE 50 GARRETT AVENUE PLE VALLEY, MN 55124		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
E 041	Emergency general must be located in a requirements found Code (NFPA 99 and Amendments TIA 1 12-5, and TIA 12-6) and Tentative Interior 12-2, TIA 12-3, and when a new structur structure or building 482.15(e)(2), §483. Emergency general [hospital, CAH and the emergency powand [maintenance] Health Care Facilities Safety Code. 482.15(e)(3), §483. Emergency general LTC facilities] that in to power emergency for how it will keep operational during the evacuates. *[For hospitals at §4 and CAHs §485.62: The standards inco section are approver reference by the Dir Federal Register in	3.73(e)(1), §485.625(e)(1) for location. The generator accordance with the location in the Health Care Facilities of Tentative Interim 2-2, TIA 12-3, TIA 12-4, TIA, Life Safety Code (NFPA 101 on Amendments TIA 12-1, TIA TIA 12-4), and NFPA 110, re is built or when an existing g is renovated. 73(e)(2), §485.625(e)(2) for inspection and testing. The LTC facility] must implement are system inspection, testing, requirements found in the est Code, NFPA 110, and Life 73(e)(3), §485.625(e)(3) for fuel. [Hospitals, CAHs and maintain an onsite fuel source by generators must have a plan emergency power systems the emergency, unless it	E	041			
		ources listed below. You may					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		E SURVEY IPLETED
		245264	B. WING	<u> </u>	03/	31/2022
	PROVIDER OR SUPPLIER TANA HCC OF APPLE	VALLEY		STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		JLD BE	(X5) COMPLETION DATE
E 041	Center, 7500 Seculor at the National A Administration (NAI availability of this m 202-741-6030, or g http://www.archives_federal_regulation If any changes in thincorporated by refedocument in the Fethe changes. (1) National Fire Pr. Batterymarch Park, Quincy, MA 02169, 1.617.770.3000. (i) NFPA 99, Health edition, issued Augili) Technical interin NFPA 99, issued Augili) TIA 12-3 to NFF (vi) TIA 12-5 to NFF (vi) TIA 12-6 to NFF (vii) NFPA 101, Life issued August 11, 2 (viii) TIA 12-1 to NF 2011. (ix) TIA 12-3 to NFF 2013. (xi) TIA 12-4 to NFF 2013. (xii) NFPA 110, Stat Standby Power Syst TIAs to chapter 7, is	e CMS Information Resource rity Boulevard, Baltimore, MD rchives and Records RA). For information on the laterial at NARA, call to to: a.gov/federal_register/code_of s/ibr_locations.html. ais edition of the Code are erence, CMS will publish a deral Register to announce otection Association, 1 www.nfpa.org, Care Facilities Code, 2012 at 11, 2011. a amendment (TIA) 12-2 to laust 11, 2011. A 99, issued August 9, 2012. A 99, issued March 7, 2013. A 99, issued March 3, 2014. Safety Code, 2012 edition,	E	041		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		MPLETED
		245264	B. WING	§	05	3/31/2022
	PROVIDER OR SUPPLIER	VALLEY		STREET ADDRESS, CITY, STATE, ZIP COI 14650 GARRETT AVENUE APPLE VALLEY, MN 55124		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		HOULD BE	(X5) COMPLETION DATE
E 041	documentation revifacility failed to mai supply systems and (2012 edition), Hea section 6.4.1.1.13, Emergency and State sections 5.6.4.5.1, and NFPA 70 (2011 Code, sections 110 110.26(C)(1) This a widespread impartacility. Findings include: During visual insperon 03/30/2022 betwit was revealed durifacility, that the gen located on an electroom. Access to the was fully obstructed addition, on 03/30/202:30 p.m., it was remost recent vendor report (Cummins 0 technician noted the in excess of 2 years between 09:30 a.m. revealed during the that the generator relocated in the area did not function or it could not be confirmannunciator panel with the policy of the confirmannunciator panel with the confirmannunciator	ction, a review of available ew and staff interview, the ntain facility emergency power of components per NFPA 99 lith Care Facilities Code, NFPA 110 (2010), Standard for andby Power Systems, 8.3, 5.6.5.6, 5.6.6, 5.6.5.2(4), 1 edition), National Electrical 1.1, 110.26, 110.26(A)(1), deficient condition could have cot on the residents within the could be residents within the end of the facility emote annunciator panel of the 1st floor Nursed Station lluminate upon testing. It med that the generator remote was operational.	E	041		
		on 3/31/22, at 10:04 a.m. the med the emergency generator				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245264	B. WING			03/:	31/2022
	PROVIDER OR SUPPLIER	VALLEY		1	TREET ADDRESS, CITY, STATE, ZIP CODE 4650 GARRETT AVENUE APPLE VALLEY, MN 55124		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
E 041	two years. The adr further information	d not been replaced in over ministrator did not provide any regarding access to the the operational status of the innunciator panel.		041			
	survey was conduct was found to be no requirements of 42	/22, a standard recertification ted at your facility. Your facility t in compliance with the CFR 483, Subpart B, ong Term Care Facilities.					
	as your allegation of Departments accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required e first page of the CMS-2567 ic submission of the POC will tion of compliance.					
F 684 SS=E	onsite revisit of you validate substantial regulations has bee Quality of Care	acceptable electronic POC, an ir facility may be conducted to compliance with the en attained.	F (684			
	applies to all treatm facility residents. Be assessment of a re that residents recei accordance with pr practice, the compressed by care plan, and the residents	fundamental principle that nent and care provided to assed on the comprehensive sident, the facility must ensure ve treatment and care in ofessional standards of rehensive person-centered					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245264	B. WING			03/:	31/2022
	PROVIDER OR SUPPLIER	VALLEY		14	TREET ADDRESS, CITY, STATE, ZIP CODE 4650 GARRETT AVENUE APPLE VALLEY, MN 55124		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	review, the facility fassess and develop comfort with poor was worsening hemorrh reviewed for position addition, the facility resident (R472) had accordance with phomplication of assaddition, the facility outside orthopedic surgical wound to exist of complication who admitted after Findings include: R39's quarterly Min 1/19/22, identified Fawheelchair for mosupervision to compliving (ADLs). On 3/28/22, at 3:07 standard wheelchair to be slouched in the positioned towards cushion and her arrothe provided wheelchair to the chair awhile back against the wall and it did not help much	cion, interview, and document ailed to comprehensively interventions to promote wheelchair posture and oids for 1 of 2 residents (R39) aning and quality of care. In failed to ensure 1 of 1 diveights monitored in aysician parameters to prevent ociated medical conditions. In failed to coordinate with an clinic to adequately monitor a ansure healing and reduce the sign of 1 residents (R375) surgery.	F	584			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		LE CONSTRUCTION		E SURVEY PLETED
		245264	B. WING	i		03/	31/2022
	PROVIDER OR SUPPLIER TANA HCC OF APPLE	VALLEY		1	STREET ADDRESS, CITY, STATE, ZIP CODE 4650 GARRETT AVENUE APPLE VALLEY, MN 55124	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 684	positioning to her kithey would." During subsequent 11:55 a.m. R39 constandard wheelchais slouched back with extended upward to rests. R39 denied a such position at this R39's care plan, las R39 used a manua was independent wheelchair while sessed any dictation positioning while sessed had ever been nor any information cushion present in to R39, had been to the lack of R39 seems wheelchair position. When interviewed on ursing assistant (Nat the nursing home noticed R39 seems wheelchair with her upward at the shoule even when reposition posture as, "[she] sand expressed R39 the wheelchair had working there. NA-C the black cushion pexpressed she had Further, NA-C state concerns about R39 as R39 expressed she sand R39 expresse	observation on 3/29/22, at attinued to use the same ir and continued to appear her arms having to be orest on the provided arm any discomfort from sitting in	F	684			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		ONSTRUCTION		E SURVEY IPLETED
		245264	B. WING			03/	31/2022
	PROVIDER OR SUPPLIER	VALLEY		14650	ET ADDRESS, CITY, STATE, ZIP CODE GARRETT AVENUE LE VALLEY, MN 55124	, 33.	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 684	the wheelchair. During interview on expressed she had months and had no wheelchair was pool hunch back when s NA-B stated she has sitting right" severa was unaware of the it, in R39's room. For unsure if therapy has wheelchair position that I know of." R39's medical recoveridence R39 had be assessed or screen positioning despite had been observed a month prior. On 3/30/22, at 10:3 manager (RN)-D stappeared "a little slawheelchair; howeved occupational therapk knowledge adding, wheelchair mapping she was unaware or room, nor when or positioning in the paseing concerns wishould bring those it was important to positioning was mapositioning could be	3/30/22, at 9:58 a.m. NA-B worked with R39 for several ticed her positioning in the or and caused R39's back to he was seated in the device. In deven told R39 "you're not a times before and added she as black cushion, nor any use of ourther, NA-B stated she was ad ever worked with R39 on ing in the past but added, "Not ard was reviewed and lacked been comprehensively ned for her wheelchair having a poor posture which by direct care staff for at least at the seated in her er, had not worked with by (OT) for this concern to her "I don't think we've done any gon her." RN-D expressed if the black cushion in R39's how it was used, for R39's last and voiced if staff were the R39's positioning they forward. Further, RN-D voiced ensure good wheelchair intained as poor posture or e "a safety concern" and to yphosis (an abnormally curved).	F	584			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG		E SURVEY MPLETED
		245264	B. WING		03/	/31/2022
	PROVIDER OR SUPPLIER	VALLEY		STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 684	occupational therap worked at the nursi R39 had not been of positioning to her k concerns with wheelevaluated and the rorders for OT to ev OT-A added it was wheelchair position timely as poor post and interventions of the longer the issue A facility' policy on verequested; however R39's quarterly Min 1/19/22, identified Frequired supervision of daily living (ADLs On 3/28/22, at 3:03 and expressed she seemed to be worstimes with increase R39 stated she thomedication she was was not routinely be When interviewed on ursing assistant (Noncerns to her about ocks "just hurt" caused NA-C to obexposed "a prolaps"	on 3/31/22, at 10:21 a.m., post (OT)-A stated she had any home for "over a year" and evaluated for wheelchair nowledge. OT-A stated any elchair positioning should be medical provider updated so aluate them can be obtained. important to ensure ing concerns were addressed ure could lead to back pain ould "get more complicated" e is allowed. Wheelchair positioning was r, none was received. Simum Data Set (MDS), dated R39 had intact cognition and n to completed most activities in a completed most activities in a complete state of late. In a complete state of late. In a complete state of late. In a complete of late.	F6	84		
		rn to the floor nurse who was				

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION DING		TE SURVEY MPLETED
NAME OF PROVIDER OR SUPPLIER AUGUSTANA HCC OF APPLE VALLEY (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPONED TO THE APPROPRIATE) COMPONED TO THE APPROPRIATE STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124			245264	B. WING		03	/31/2022
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE D. D			VALLEY		14650 GARRETT AVENUE	•	
	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	(X5) COMPLETION DATE
working. Further, NA-C stated she was not aware of any medication being placed or given to help R39 with the issue and associated discomfort. R39's medical record was reviewed and lacked any evidence R39's worsening hemorrhoids had been assessed or interventions developed to reduce and/or eliminate them or the associated discomfort from them despite direct care staff having knowledge of the issue. On 3/30/22, at 10:30 a.m. registered nurse unit manager (RN)-D was interviewed and expressed she was unaware R39 had been having issues with her hemorrhoids. RN-D explained if a resident has such issues, then staff should report it so the nursing staff can go in to "check the area" and coordinate a treatment plan with the medical provider which could include the use of Tuck Pads or other cream-based products. RN-D reviewed R39's Medication Administration Record (MAR) and verified there had been not reatments for R39's hemorrhoids in the past few months, nor was there any evidence in the medical record the issue had been assessed or addressed. RN-D stated the reported worsening hemorrhoids should have been addressed right away as the condition could worsen. A facility provided Change In Condition policy, dated 2/20/20, identified the nurse would notify the attending physician or on-call physicians with several scenarios listed including, " need to alter the resident's medical treatment significantly." However, prior to such notification, the policy directed, " the nurse will make detailed observations and gather relevant and pertinent information (complete SBAR; Situation Background Assessment and Response) for the	F 684	working. Further, Nof any medication be R39 with the issue R39's medical recording evidence R39's been assessed or in reduce and/or elimit discomfort from the having knowledge of the condition of the having knowledge of the ha	A-C stated she was not aware being placed or given to help and associated discomfort. In a was reviewed and lacked a worsening hemorrhoids had interventions developed to inate them or the associated and despite direct care staff of the issue. In a.m. registered nurse unit was interviewed and expressed and expressed and says had been having issues destard. The area would report aff can go in to "check the tere a treatment plan with the hich could include the use of a cream-based products. RN-D adication Administration Record there had been no treatments bids in the past few months, evidence in the medical record assessed or addressed. Ported worsening hemorrhoids addressed right away as the reen. Change In Condition policy, tified the nurse would notify the for on-call physicians with isted including, " need to medical treatment ever, prior to such notification, " the nurse will make and gather relevant and on (complete SBAR; Situation)	F	584		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED
		245264	B. WING	·		03/	31/2022
	PROVIDER OR SUPPLIER TANA HCC OF APPLE	VALLEY			STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	indicated R472 was diagnoses of edem R472's provider ordaily weights and a gain of more than 2 per week. R472's weight log, record (MAR), and 3/31/22, indicated F days from 3/23/22, R472's care plan days from 3/23/22, When interviewed R472 stated her leg supposed to have a staff was not weight was concerned about the staff was not weight and retention) dosi Further, R472 indicated breath while sitting excess fluid. R472	rogress note printed 3/31/22, standitted 3/23/22, with a and chronic heart failure. ders dated 3/23/22, indicated call to the provider for weight 2 pounds per day, or 5 pounds medication administration progress notes printed R472 was not weighed 2 of 8 to 3/31/22. ated 3/23/22, indicated daily ncreases in weight to provider one day, or 5# in one week. on 03/29/22, at 11:29 a.m. gs were swollen and she was daily morning weights, but ing her daily. R472 stated she but not getting daily weights nide (medication to reduce ng depended upon her weight. Stated she was more short of which she stated was due to stated she was not normally	F	684	,		
	When interviewed of licensed practical in resident had an ord had not been done. When interviewed of	on 3/29/22, at 10:57 a.m. surse (LPN)-A stated the der for daily weights, and they as ordered. on 3/30/22, at 8:25 a.m.					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		LE CONSTRUCTION		E SURVEY IPLETED
		245264	B. WING			03/	31/2022
	PROVIDER OR SUPPLIER TANA HCC OF APPLE	VALLEY		1	STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 684	were not recorded of When interviewed of acting director of nu expectation was that the daily weights as nurse, and the nurs medical record. The follow the orders as the resident could be complications, and The facility's Weight 6/17/20, indicated with the control of the facility of th	daily, and did not know why. on 3/31/22, at 11:04 a.m. the ursing (DON) stated the at nursing assistants would get a ordered, report them to the se would record them in the e DON stated the policy was to a written, and if they were not, have fluid overload, heart increased edema. It Measurement policy revised weigh each resident monthly ordered by physician to occur record the weight in the	F	684			
	cognitively intact, di extensive assistant living (ADL's) had a required surgical with R375's care plan da surgical incision on to complete a body observation. Staff wof infection or not h provider as needed R375's Physician C indicated R375 was 100 mg every 12 hd p.m. until 3/21/22, f knee joint. The order	ated 3/18/22, identified a right knee and directed staff audit and weekly skin were also to monitor for signs ealing and were to update the					

	MENT OF DEFICIENCIES DEAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE COMP		E SURVEY PLETED				
		245264	B. WING			03/:	31/2022
	PROVIDER OR SUPPLIER TANA HCC OF APPLE	VALLEY		14	TREET ADDRESS, CITY, STATE, ZIP CODE 4650 GARRETT AVENUE PPLE VALLEY, MN 55124		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 684	R375's Visual Body lacked any mention R375's Visual Body lacked any mention R375's Compreher scale used to measure injuries) a incomplete and lack assessment or obstor pressure injury assistance with AD listed in section "O' left unmarked. R375's Physician O'-3/18/22, R375 was as instructed, howe included3/21/22, Consult with practitioner (NP)-A R375's right knees evidence NP-A was R375's Physician NR375 complained of her right knee. The had not attended hup appointment with and that R375 did in rescheduled. The right cotor (MD)-A wouregarding the removes	age 21 Included and no follow up was In provided and and and and and and and and and an	F	584			

	OF DEFICIENCIES OF CORRECTION				SURVEY PLETED		
		245264	B. WING			03/	31/2022
	PROVIDER OR SUPPLIER	VALLEY		STREET ADDRESS, CITY, STATE, ZIP CO 14650 GARRETT AVENUE APPLE VALLEY, MN 55124	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORI X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD I	BE	(X5) COMPLETION DATE
F 684	at 2:13 p.m. R375 sher right total knee was discharged hor 3/10/22. R375 had the surgical team showever, on 3/16/2 department due to ankles. R375 remains and was released to on 3/18/22, with a cunrelated to her surfarriving at the facility medical portal (MY appointment but sa stated she had not was not sure who had knowledge, the followen rescheduled. bandage was to remove to the appointment went to the appointment went to the appointment but to the appointment but to the appointment of the surgical inches wide with cleextended approximate bandage on all side bandage was intact. The skin surroundir extremely dry, white intact with no redner of the surgical incises bandage.	and observation on 3/28/22, stated she had a revision of replacement on 3/9/22. R375 me after her surgery on a follow up appointment with cheduled for 3/22/22, 2, she went to the emergency extreme pain in her feet and ined in the hospital for 2 days of the facility for rehabilitation, liagnosis of gouty arthritis rgery. R375 stated after cy, she looked at her online Chart) to verify her follow up with had been canceled. R375 canceled the appointment and ad. R375 also stated, to her ow up appointment had not R375 stated her surgical main on her right knee until the ent, however, since she never ment, the bandage was still on to been removed or assessed R375 was observed to have a roximately 6 inches long and 2 ear adhesive over top that ately one inch wider than the standard appeared clean and dry. In R375's bandage was and flaky, but otherwise ear of laky, but otherwise ear of laky.	F 6	84			
		dressing to R3/5's right knee no redness, drainage, or signs					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245264	B. WING			03/	31/2022
NAME OF PROVIDER OR SUPPLIER AUGUSTANA HCC OF APPLE VALLEY				14	TREET ADDRESS, CITY, STATE, ZIP CODE 4650 GARRETT AVENUE PPLE VALLEY, MN 55124		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	of infection were no open to air. During an interview R375 stated the surremoved by a nurse During an interview Twin City Orthoped (CC-A) stated becar appointment with the canceled, NP-A short R375's surgical incides assessed for signs CC-A further stated picture of R375's surgical team s R375 discharged her During an interview Fairview surgical Cappointment on 3/2 canceled by the fact operative follow up team would not have During an interview facility physician's as she saw R375 on 3 R375's knee becaus till covering it. PAdischarged to her pamany of R375's poswere missed by the had been admitted her knee surgery, Fassessed by the fact However, because	on 3/29/22, at 11:32 a.m. rgical bandage had been the previous evening. on 3/30/22, at 11:22 a.m. rics (TCO) care coordinator use R375's follow up the surgical team had been ould have been notified and rision should have been of infection and dehiscence. If wanted the staff to take a surgical incision and send it to they could assess it before that afternoon. on 3/30/22, at 12:18 p.m. C-B stated R375's follow up 2/22, would have been illity because the post is important and the surgical	F	684			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245264	B. WING _		03/	31/2022
NAME OF PROVIDER OR SUPPLIER AUGUSTANA HCC OF APPLE VALLEY				STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	missed. PA-A also se canceled R375's for surgical team on 3/2 was unaware that Finot been removed a until the evening of would have been contained the evening of would have been contained to separate infected if it had not three weeks after the During an interview MD-A verified the owith NP-A. MD-A did done and the facility it. MD-A also stated 3/25/22, and noted 3/9/22, was still on The facility Skin Interior indicated licensed shead-to-toe inspect admission to the facility in the residence of (EMR). The treat existing skin complemented based assessment and contained in the indicated licensed skin complemented based assessment and contained in the emission of the resident's skin the EMR. NAs were during routine cares licensed nurse. Residence in the alteration's location in alteration's location.	stated she did not know who llow up appointment with the 22/22. PA-A further stated she 2375's surgical dressing had and the incision site assessed 3/28/22. PA-A stated there oncern that the incision could emplication causing the and open) or become the been assessed for almost the surgery was performed. on 3/30/22, at 12:32 p.m. and and the incision could omplication causing the surgery was performed. on 3/30/22, at 12:32 p.m. and and the surgical dressing from the surgical dressing from the surgical dressing from R375's right knee. egrity policy dated 2/4/21, staff would perform a ion of their skin upon cility and document their ent's electronic medical care plan and interventions to	F 684	4		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245264	B. WING			03/:	31/2022
NAME OF PROVIDER OR SUPPLIER AUGUSTANA HCC OF APPLE VALLEY				14	TREET ADDRESS, CITY, STATE, ZIP CODE 1650 GARRETT AVENUE PPLE VALLEY, MN 55124		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880 F 880 SS=E	§483.80 Infection Control of the facility must estinfection prevention designed to provide comfortable enviror development and tradiseases and infection program. The facility must estand control program a minimum, the following services of the providing services of the but are not limited to the facility when and to who communicable diserported; (iii) Standard and traditional standard and traditional services of the persons in the facility when and to who communicable diserported; (iii) Standard and traditional standard and traditional services in the facility when and to who communicable diserported; (iii) Standard and traditional services in the facility when and to who communicable diserported; (iii) Standard and traditional services in the facility when and to who communicable diserported; (iii) Standard and traditional services in the facility when and to who communicable diserported; (iii) Standard and traditional services in the facility when and to who communicable diserported; (iii) Standard and traditional services in the facility of the facil	an & Control 1)(2)(4)(e)(f) control stablish and maintain an and control program a safe, sanitary and ament and to help prevent the ransmission of communicable tions. In prevention and control stablish an infection prevention of (IPCP) that must include, at owing elements: Item for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual of upon the facility assessmenting to §483.70(e) and following standards; en standards, policies, and program, which must include, or eillance designed to identify table diseases or ey can spread to other	F 8 F 8				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245264	B. WING		03/3	31/2022
NAME OF PROVIDER OR SUPPLIER AUGUSTANA HCC OF APPLE VALLEY				STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124		_
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		BE	(X5) COMPLETION DATE
F 880	resident; including to (A) The type and do depending upon the involved, and (B) A requirement to least restrictive poscircumstances. (v) The circumstances (v) The circumstance must prohibit emploisease or infected contact with resider contact will transmit (vi)The hand hygier by staff involved in \$483.80(a)(4) A systidentified under the corrective actions to \$483.80(e) Linens. Personnel must had transport linens so infection. §483.80(f) Annual rougher than the facility will concomple and update the this REQUIREMENT by: Based on observation review the facility fa	solation should be used for a put not limited to: uration of the isolation, a infectious agent or organism that the isolation should be the sible for the resident under the ces under which the facility byees with a communicable skin lesions from direct at the disease; and the procedures to be followed direct resident contact. Stem for recording incidents facility's IPCP and the taken by the facility. Indle, store, process, and as to prevent the spread of	F 8	380		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245264	B. WING			03/	31/2022
	PROVIDER OR SUPPLIER	VALLEY		STREET ADDRESS, CI 14650 GARRETT AVE APPLE VALLEY, N	ENUE	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORF	R'S PLAN OF CORRECTIC RECTIVE ACTION SHOULI RENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 880	all 19 residents on same staff. Findings include: R68's admission M 2/22/22, indicated F deficits with diagno septic shock (an int throughout the body chronic kidney dise anticoagulant use (Clostridium difficile assistance of two sand extensive assis hygiene. Transfers the assessment an R68's Care Area As 2/22/22, indicated F loss, urinary incontinuell-being, dehydrating R68's progress not indicated R68's stopositive for C-Diff awas placed on cont to wash his hands whand sanitizer. R120's admission MR120 was cognitive urinary tract infections.	inimum Data Set (MDS) dated R68 had moderate cognitive ses of severe sepsis with fection that has spread y and is life threatening), ase, morbid obesity, blood thinners), and R68 required extensive taff for bed mobility, toileting, stance of one staff for personal occurred once or twice during d required two staff. Seessments (CAAs) dated R68 triggered for cognitive nence, psychosocial tion, and pressure ulcers. Le dated 3/27/22, at 4:08 p.m. ol sample was reported t 1:30 p.m. on 3/27/22. R68 act precautions and advised using soap and water and not MDS dated 3/19/22, indicated by intact with diagnoses of on, acute respiratory failure axygen), chronic kidney disease	F	80			
	on 3/28/22, from 12	s observation and interviews 2:36 p.m. to 12:50 p.m. an n-based precautions (TBP)					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	TIPLE CONSTRUCTION ING		E SURVEY MPLETED
		245264	B. WING		03/	/31/2022
	PROVIDER OR SUPPLIER TANA HCC OF APPLE	VALLEY		STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ILD BE	(X5) COMPLETION DATE
F 880	sign was posted on R68 (window side) The sign indicated must: clean their hagown and gloves at everyone was to wawater. Nursing assi 121 wearing a surg gloves as indicated R68 was recently difficile. NA-E state indicated gowns an entering the resider nurse and had learn when providing directly wearing a surg but no gown or gloveray on his bedside to the left side of his face the television. Wheelchair on the resident of the left were now sitting net elevision, less than pushed the curtain residents back fare could view each of not their faces. SW she did not know whand sanitizer when and gowns were or direct care such as resident in their whon to usually deliver read the TBP sign presidents.	the door to room 121 where and R120 (door side) resided. everyone entering the room ands with sanitizer and wear and, upon exiting the room, ash their hands with soap and stant (NA)-E entered room ical mask, but no gown or by the TBP sign. NA-E stated iagnosed with Clostridium ed, although the TBP sign d gloves were required upon at room, NA-E was a student ned they were only required ect cares. Social worker d room 121 carrying a meal ical mask and eye protection res. SW-A placed R120's meal table and positioned the table is bed, towards R68's bed, to R68 was sitting in his ight side of his bed toward cing the television. SW-A then is wheelchair, behind his of his bed. R68 and R120 axt to each other facing the intree feet apart. SW-A divider between the two enough that R68 and R120 are smeal trays, and legs but required when providing toileting; not when pushing a pelchair. SW-A stated she did resident meals and had not prior to entering room 121. The of the requirement to wash	FE			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		E SURVEY MPLETED
		245264	B. WING _		03/	31/2022
	PROVIDER OR SUPPLIER	VALLEY		STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 880	her hands upon exi was supposed to w sink. During a continuous 3/28/22, at 4:53 p.n stated R68 had beedue to his recent diclear plastic bag of previous bed and the was covered with p bedding, a dumbbe and bottles. The TE from the door leaving remained contaminentering the room of infected and spread R68's items and be personal protective gowns and gloves. R68's room without up R68's walker, gaup items from the flof clothing from the the hall to R68's ne should have worn a touching R68's personal protective gowns and gloves. R68's meshould have worn a touching R68's personal protective gowns and gloves. R68's new from the flof clothing from the the hall to R68's ne should have worn a touching R68's personal protective gowns and gloves. R68's new room removing an observat at 11:42 a.m. nursing R68's new room removing gloves from the support of R68's new room rem	ting the room and asked if she ash them in the residents' sobservation and interview on a registered nurse (RN)-Hen moved to a private room agnosis of C-Diff. A large, clothing was on R68's ne windowsill next to his bed ersonal items such as urinals, ll weight, and various lotions BP sign had been removed ag no indication the room ated. RN-H stated anyone could become contaminated or a the bacteria if they handled dding without wearing proper equipment (PPE) such as At 5:18 p.m. RN-H entered a gown or gloves and picked ait belt, a grabber used to pick oor, and the large plastic bag bed and carried them down we room. RN-H stated she gown and gloves when sonal items as they could lothing and contaminate them. personal items remained on 68's room with no indication	F 88			
	of R68's new room removing gloves fro balled the gloves in gait belt as she wal	carrying a gait belt and om her hands. NA-D then				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY IPLETED
		245264	B. WING _		03/	31/2022
	PROVIDER OR SUPPLIER TANA HCC OF APPLE	VALLEY		STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 880	towel up off the floogown because the finot providing cares occurred to her that contaminated. During observation 1:10 p.m. R68's old the bed was made. seen, remained as and a green sling utransferring resident such as a bed and door. Maintenance and explained he window. MT-A then moved it out of his entered the room a and sling belonged brought to R68's new MT-A stated he was to R68 and were portion of the provided in the remove and dispostering a resident' for C-Diff. Staff shows before entering the remove and disposterion of the provided in the remove and disposterion of the provided in the prov	ge 30 or but had not worn gloves or a towel was clean, and she was to R68. NA-D stated it had not at the towel could have been and interview on 3/29/22, at a room had been cleaned and The dumbbell previously the only item on the windowsill sed with a hydraulic lift when at from one surface to another toilet, hung on the bathroom (MT)-A entered R68's room as going to be working on the picked up the dumbbell and way on the windowsill. NA-E and confirmed the dumbbell to R68 and should have been as wroom the previous day. It is unaware the items belonged assibly contaminated. on 3/31/22, at 11:28 a.m. the pist (IP) stated staff were to an and donning gloves, and gloves when as room who is on enteric TBP and the providing direct care or comment of a resident on TBP including wheelchairs and bed V-A should have worn a gown the assisted R120 and SW-A do her hands prior to leaving the cross-contamination. IP also	F 88			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION ING		E SURVEY PLETED
		245264	B. WING		03/:	31/2022
	PROVIDER OR SUPPLIER ANA HCC OF APPLE	VALLEY		STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		BE	(X5) COMPLETION DATE
F 883 SS=D	removed prior to Reavoid possible contavoid possible contavoid possible contavoid possible contavoid possible contavoid possible contavoid to entering rooms of cross contamination were not infected at staff were to follow. The facility Clostridic policy dated 10/26/2 could live on surfact months and staff contavoid hand contavoid contaminated surfact prior to entering a resuspected CDI and room. Gowns were direct care or when resident's environm Influenza and Pneu CFR(s): 483.80(d) (1) §483.80(d) (1) Influenza and proced (i) Before offering the each resident or the	I and sling should have been 68's area being cleaned to amination. on 3/31/22, at 12:00 p.m. the ursing (DON) stated masks, gloves were to be worn prior f residents on TBP to avoid n of residents or staff who The DON further stated the the facility policy. um Difficile Infection (CDI) 21, indicated C-Diff spores es in the environment for ould spread the bacteria ct after touching a ce. Gloves were to be worn esident's room with known or removed prior to exiting the to be worn while providing coming into contact with the ent. mococcal Immunizations 1)(2) a and pneumococcal enza. The facility must develop ures to ensure that-ne influenza immunization, e resident's representative	F 8	880		
	potential side effect (ii) Each resident is immunization Octob annually, unless the	regarding the benefits and s of the immunization; offered an influenza per 1 through March 31 immunization is medically the resident has already been				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ING			E SURVEY PLETED
		245264	B. WING			03/	31/2022
	PROVIDER OR SUPPLIER TANA HCC OF APPLE	VALLEY		STREET ADDRESS, CIT 14650 GARRETT AVE APPLE VALLEY, M	NUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X (EACH CORR	ES PLAN OF CORRECTION ECTIVE ACTION SHOULD ENCED TO THE APPROPN DEFICIENCY)	BE	(X5) COMPLETION DATE
F 883	immunized during t (iii) The resident or has the opportunity (iv)The resident's m documentation that following: (A) That the resider was provided educa and potential side e immunization; and (B) That the resider immunization or dic immunization due to refusal. §483.80(d)(2) Pneu must develop polici that- (i) Before offering th immunization, each representative rece benefits and potent immunization; (ii) Each resident is immunization, unles medically contraind already been immu (iii) The resident or has the opportunity (iv)The resident's m documentation that following: (A) That the resider was provided educa and potential side e immunization; and (B) That the resider	the resident's representative to refuse immunization; and nedical record includes indicates, at a minimum, the nt or resident's representative ation regarding the benefits effects of influenza in either received the influenza in not receive the influenza or medical contraindications or immococcal disease. The facility es and procedures to ensure the pneumococcal in resident or the resident's ives education regarding the ial side effects of the offered a pneumococcal is the immunization is icated or the resident has	F	83			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3)			ATE SURVEY DMPLETED	
		245264	B. WING		0	3/31/2022
	PROVIDER OR SUPPLIER	VALLEY		STREET ADDRESS, CITY, STATE, ZIP CO 14650 GARRETT AVENUE APPLE VALLEY, MN 55124		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE
F 883	contraindication or This REQUIREMEN by: Based on interview facility failed to ension offered and provide reviewed for immur. Findings include: R27's Admission Reindicated R27 was been admitted to th. R27's admission M 1/11/22, indicated Finfluenza vaccination any further informativaccination. R27's medical recowas offered or receducation about the R27's Minnesota Im Connection (MIIC) R27's last influenza on 3/30/22, at 12:0 preventionist (IP) whas not assessed Fivaccine. The IP assiduring the interview an influenza vaccin R27 should have haupon admission.	immunization due to medical refusal. NT is not met as evidenced and document review, the ure an influenza vaccine was ed to 1 of 5 residents (R27) nizations. ecord printed 3/31/22, over 65 years old, and had e facility on 1/6/22. inimum Data Set (MDS) dated R27 had not received the on upon admission and lacked tion about influenza rd lacked evidence that R27 inved the influenza vaccine, nor	F8	383		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245264	B. WING			03/31/2022
	PROVIDER OR SUPPLIER	VALLEY		STREET ADDRESS, CITY, STAT 14650 GARRETT AVENUE APPLE VALLEY, MN 551		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN X (EACH CORRECTIVE CROSS-REFERENCED DEFICE	ACTION SHOULD BE TO THE APPROPRIAT	(X5) COMPLETION DATE
F 921 SS=D	stated she would exinfluenza vaccine useducation provided DON confirmed the influenza immuniza addressed or docur. The Center for Discidentified everyone recommended to grannually, with rare of the facility's Influence of the vaccine annually indicated about influence of the vaccine annually indicated. Safe/Functional/Sa CFR(s): 483.90(i) §483.90(i) Other Enthe facility must prosanitary, and comforesidents, staff and This REQUIREMENCE of the vaccine annually indicated. Safe/Functional/Sa CFR(s): 483.90(i) §483.90(i) Other Enthe facility for the facility must prosanitary, and comforesidents, staff and This REQUIREMENCE of the facility for the	(DON) was interviewed and spect the nurses to offer pon admission, document, or document refusal. The ere was no evidence R27's tion status had been mented during admission. The ease Control and Prevention of months and older are et an influenza vaccination exceptions. The exceptions are policy revised esidents would be assessed for excine upon admission, uenza vaccination, and offered by or upon admission as entary/Comfortable Environ entary/Comfortable Environ entable environment for the public. The public environment for the public environment as evidenced evidenced and in sanitary residents (R12 and R33) entange Minimum Data Set entarge Minimum Data Set entarge Minimum Data Set	F 8	883		
		2, indicated R12 cognition was				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION DING		DATE SURVEY COMPLETED	
		245264	B. WING			03/31/2022	
	PROVIDER OR SUPPLIER TANA HCC OF APPLE	VALLEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE	
F 921	protein-calorie malinad a feeding tube calories received the feeding during the operiod. R33's quarterly MD R33's cognition was diagnoses included R33 had a feeding total calories received feeding during the operiod. During observation was lying in bed. Final calories received feeding during the operiod. During observation was lying in bed. Final calories received feeding ender the pole. During observation tube feeding equipment of the pole and bas wasn't running and a container of tan of the pump with the open to air with smiliquid in the tip. During observation was lying in bed. Final calories received the pump with the open to air with smiliquid in the tip.	age 35 R12's diagnoses included nutrition and dysphagia. R12 and had 51% or more of total grough parenteral or tube entire seven day look back S dated 1/18/22, indicated as severely impaired. R33's malnutrition and dysphagia. Tube and had 51% or more of red through parenteral or tube entire seven day look back on 3/29/22, at 12:04 p.m. R12 at 2's tube feeding equipment mount of dried tan colored on the pump, the pole and the consumprise of the second second in the pump was at the bedside. R12 had colored liquid formula attached to tubing hanging and the tip all amount of tried tan colored dried on 3/29/22, at 12:06 p.m. R33 at 3's tube feeding equipment mount of dried tan colored hours of dried tan colored hours of dried tan colored	FS	,			
	base of the pole. .During observation	on the pump, the pole and the n on 3/20/22, at 8:52 a.m. equipment was observed to					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245264	B. WING		03/	31/2022	
	PROVIDER OR SUPPLIER TANA HCC OF APPLE	VALLEY		STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 921	on the pump, pole a pump wasn't runnin R33 had a containe attached to the punthe tip open to air woolored dried liquid. During interview on registered nurse (Rof which staff memediappment. RN-A wasn'ts and R33's tulunsanitary and look been on the equipment. Puring interview on nursing assistant (Nous chedule for cleaning Further, NA-A state cleaned when it is rowerified the current tube feeding equipment and been on the equipment and wasn't a schedule feeding equipment e	e dried tan substance present and base. R33's tube feeding and was at the bedside. For of tan colored liquid formula app with the tubing hanging and with small amount of tan in the tip. 3/30/22, at 10:33 a.m. 3/30/24, at 10:35 a.m. 3/30/26 to the current condition of the feeding equipment was steed like the dried formula had	F 9	21			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered April 20, 2022

Administrator Augustana HCC Of Apple Valley 14650 Garrett Avenue Apple Valley, MN 55124

Re: State Nursing Home Licensing Orders

Event ID: F8UY11

Dear Administrator:

The above facility was surveyed on March 28, 2022 through March 31, 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 <u>only a suggestion</u> 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

Augustana HCC Of Apple Valley April 20, 2022 Page 2

"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:

Pete Cole, RN Unit Supervisor Metro Team C District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 85 East Seventh Place, Suite 220 P.O. Box 64900 Saint Paul, Minnesota 55164-0900 Email: peter.cole@state.mn.us Office/Mobile: (651) 249-1724

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health

Kumala Fiske Downing

Licensing and Certification Program

Augustana HCC Of Apple Valley April 20, 2022 Page 3

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: <u>Kamala.Fiske-Downing@state.mn.us</u>

PRINTED: 04/20/2022 FORM APPROVED

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00979	B. WING		03/3	1/2022
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
AUGUST	TANA HCC OF APPLE	VΔIIFY	RRETT AVE ALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the deficing herein are not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all a rule provided at the tagule number indicated below. In the several items, failure to the items will be considered below and the items will be considered below the item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these it a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	conducted at your f Minnesota Departm facility was found no State Licensure and orders are issued. I	TS: 22, a licensing survey was acility by surveyors from the nent of Health (MDH). Your ot in compliance with the MN d the following correction Please indicate in your prection you have reviewed				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BUILDING:			
		00979	B. WING		03/3	1/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AUGUS	TANA HCC OF APPLE	VALLEY	RRETT AVE			
0// 15	CHMMADV CTA	AFFLE VI	ALLEY, MN	PROVIDER'S PLAN OF CORRECTI	ON	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Continued From pa	ige 1	2 000			
	these orders and id be completed.	lentify the date when they will				
	the State Licensing federal software. To assigned to Minnes Nursing Homes. The appears in the far letter ag." The state statisted in the "Summer column and replace the correction order the findings which a statute after the state as evidence by." For are the Suggested Time period for Contraction of State lice the Minnesota Dep Informational Bulleth Minnesota Dep Informational Bulleth Minnesota Dep Informational Bulleth Minnesota Department of Hear you electronically is necessary for State licensure proceed prior to empletion date, the corrected prior to emplete date.	participate in the electronic ensure orders consistent with artment of Health tin state.mn.us/facilities/regulatio _1.html The State licensing ed on the attached Minnesota lth orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health.				

Minnesota Department of Health

STATE FORM F8UY11 If continuation sheet 2 of 23

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00979	B. WING		02/2	1/2022
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	03/3	1/2022
		14650 GA	RRETT AVE	•		
AUGUST	ANA HCC OF APPLE	APPLE VA	ALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	IS NO REQUIREM CORRECTION FO	R ON EACH PAGE. THERE ENT TO SUBMIT A PLAN OF R VIOLATIONS OF E STATUTES/RULES.				
2 830	MN Rule 4658.0520 Proper Nursing Car	O Subp. 1 Adequate and re; General	2 830			
	receive nursing carcustodial care, and individual needs and the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the custodial care.	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.				
	by: Based on observation review, the facility for assess and develop comfort with poor worsening hemorrh reviewed for position addition, the facility resident (R472) had accordance with photocomplication of assentiation, the facility outside orthopedic surgical wound to exercise.	on, interview, and document ailed to comprehensively interventions to promote theelchair posture and oids for 1 of 2 residents (R39) aning and quality of care. In failed to ensure 1 of 1 dweights monitored in eysician parameters to prevent ociated medical conditions. In failed to coordinate with an clinic to adequately monitor a ensure healing and reduce the s for 1 of 1 residents (R375)				

Minnesota Department of Health

STATE FORM F8UY11 If continuation sheet 3 of 23

AND DIAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00979	B. WING		03/3	1/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AUGUST	TANA HCC OF APPLE	VΔIIFY	RRETT AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 3	2 830			
	who admitted after	surgery.				
	Findings include:					
	1/19/22, identified F a wheelchair for mo	imum Data Set (MDS), dated R39 had intact cognition, used obility, and required oleted most activities of daily				
	standard wheelchai to be slouched in th positioned towards cushion and her arr the provided wheelc interviewed at this t not like her wheelch old and falling apart black cushion to he the chair awhile bac against the wall and it did not help much been screened or e	p.m. R39 was seated in a ir in her room. R39 appeared the wheelchair with her buttocks the front of the wheelchair ms extended upward to rest on chair armrests. R39 was the immediate and expressed she did hair as it was, "about 20 years t." R39 stated she tried using a lip improve her positioning in ck, and pointed to it stored the cabinet; however, stated in R39 stated she had never evaluated for her wheelchair mowledge but added, "I wish				
	11:55 a.m. R39 con standard wheelchai slouched back with extended upward to	observation on 3/29/22, at a strinued to use the same of and continued to appear ther arms having to be or rest on the provided arm any discomfort from sitting in stime.				
	R39 used a manual was independent w lacked any dictation	st revised 1/26/22, identified I wheelchair for mobility and ith it's use. The care plan n or documentation on R39's sated in the wheelchair or if				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILBING.			
		00979	B. WING		03/3	1/2022
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
AUGUST	ANA HCC OF APPLE	VALLEY	RRETT AVE ALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
	nor any information cushion present in to R39, had been to wheelchair position. When interviewed conursing assistant (Nat the nursing home noticed R39 seems wheelchair with her upward at the shoule even when reposition posture as, "[she] so and expressed R39 the wheelchair had working there. NA-6 the black cushion pexpressed she had	evaluated by therapy for such; on the use of the black R39's room which, according rialed in the past for her ing without success. on 3/30/22 at 9:19 a.m., NA)-C stated she had worked e for "about a month" and had ed to appear slouched in her arms having to extend lder to rest on the armrests oned. NA-C described R39's chlumped back" in the chair b's posture and positioning in been such since she started C stated she was unaware of present in R39's room and never used it with R39 prior.				
	concerns about R3 as R39 expressed sfelt, overall, R39 "bithe wheelchair. During interview on expressed she had months and had nowheelchair was pool hunch back when sitting right" severa was unaware of the it, in R39's room. For unsure if therapy had wheelchair position that I know of."	9's posture in the wheelchair she "is fine" with it and NA-C arely shlumps" while seated in 3/30/22, at 9:58 a.m. NA-B worked with R39 for several sticed her positioning in the or and caused R39's back to she was seated in the device. It is before and added she black cushion, nor any use of urther, NA-B stated she was ad ever worked with R39 on ing in the past but added, "Not ard was reviewed and lacked been comprehensively				

Minnesota Department of Health

STATE FORM F8UY11 If continuation sheet 5 of 23

NAME OF PROVIDER OR SUPPLIER B. WING 03/31/20	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS CITY STATE ZID CODE	
	ROVIDER OR SUPPL
AUGUSTANA HCC OF APPLE VALLEY APPLE VALLEY, MN 55124	ANA HCC OF API
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(EACH DEFICIE
2 830 Continued From page 5 assessed or screened for her wheelchair positioning despite having a poor posture which had been observed by direct care staff for at least a month prior. On 3/30/22, at 10:30 a.m. registered nurse unit manager (RN)-D stated she had noticed R39 appeared "a little slouched" while seated in her wheelchair, however, had not worked with occupational therapy (OT) for this concern to her knowledge adding, "I don't think we've done any wheelchair mapping on her." RN-D expressed she was unaware of the black cushion in R39's room, nor when or how it was used, for R39's positioning in the past and voiced if staff were seeing concerns with R39's positioning in they should bring those forward. Further, RN-D voiced it was important to ensure good wheelchair positioning was maintained as poor posture or positioning could be "a safety concern" and to reduce the risk of kyphosis (an abnormally curved spine) or other concern. When interviewed on 3/31/22, at 10:21 a.m., occupational therapist (OT)-A stated she had worked at the nursing home for "over a year" and R39 had not been evaluated for wheelchair positioning to her knowledge. OT-A stated any concerns with wheelchair positioning should be evaluated and the medical provider updated so orders for OT to evaluate them can be obtained. OT-A added it was important to ensure wheelchair positioning coomers were addressed timely as poor posture could lead to back pain and interventions could "get more complicated" the longer the issue is allowed. A facility' policy on wheelchair positioning was requested; however, none was received.	assessed or sor positioning desphad been obser a month prior. On 3/30/22, at a manager (RN)-lappeared "a littly wheelchair; how occupational the knowledge addi wheelchair mapshe was unawaroom, nor when positioning in the seeing concerns should bring the it was important positioning was positioning coul reduce the risk spine) or other of the worked at the nr R39 had not be positioning to he concerns with we evaluated and the concerns with we evaluated and the concerns with we walked it with the longer the is A facility' policy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00979	B. WING		03/3	31/2022
	PROVIDER OR SUPPLIER	VALLEY 14650 GA	DDRESS, CITY, S ARRETT AVE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	R39's quarterly Min 1/19/22, identified Frequired supervision of daily living (ADLs On 3/28/22, at 3:03 and expressed she seemed to be worstimes with increase R39 stated she thormedication she was was not routinely be When interviewed on ursing assistant (Noncerns to her about worsening hemorrh buttocks "just hurt" caused NA-C to obe exposed "a prolaps reported the concerworking. Further, Nof any medication be R39 with the issue at R39's medical record any evidence R39's been assessed or in reduce and/or elimit discomfort from the having knowledge of On 3/30/22, at 10:3 manager (RN)-D was he was unaware Fwith her hemorrhoid resident has such is it so the nursing statarea" and coordinate	imum Data Set (MDS), dated R39 had intact cognition and in to completed most activities is). p.m. R39 was interviewed had hemorrhoids which ening and quite painful at dibleeding noticed as of late. Light there was some is taking for them; however, it eing given. On 3/30/22, at 9:19 a.m. NA)-C stated R39 had reported but a month prior about her oids. R39 had expressed her because of them which serve R39's rectum which ed hemorrhoid," so she into the floor nurse who was A-C stated she was not aware being placed or given to help and associated discomfort. In was reviewed and lacked is worsening hemorrhoids had interventions developed to nate them or the associated and despite direct care staff				

Minnesota Department of Health

STATE FORM F8UY11 If continuation sheet 7 of 23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED	
		00979	B. WING		03/	31/2022
	PROVIDER OR SUPPLIER	VALLEY 14650 GA	DRESS, CITY, S RRETT AVE ALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
2 830	Tuck Pads or other reviewed R39's Me (MAR) and verified for R39's hemorrho nor was there any ethe issue had been RN-D stated the reshould have been a condition could wor. A facility' provided of dated 2/2020, identiated attending physician several scenarios lialter the resident's significantly." Howe the policy directed, detailed observation pertinent information.	cream-based products. RN-D dication Administration Record there had been no treatments ids in the past few months, evidence in the medical record assessed or addressed. Forted worsening hemorrhoids addressed right away as the sen. Change In Condition policy, ified the nurse would notify the or on-call physicians with sted including, " need to	2 830			
	indicated R472 was diagnoses of edem R472's provider ord daily weights and a	rogress note printed 3/31/22, s admitted 3/23/22, with a and chronic heart failure. Hers dated 3/23/22, indicated call to the provider for weight pounds per day, or 5 pounds				
	R472's weight log, I record (MAR), and 3/31/22, indicated F days from 3/23/22,	medication administration progress notes printed R472 was not weighed 2 of 8 to 3/31/22.				

Minnesota Department of Health

STATE FORM F8UY11 If continuation sheet 8 of 23

STATEME	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00979	B. WING		03/3	1/2022
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 00/0	172022
AUGUS	TANA HCC OF APPLE	VALLEY	RRETT AVE ALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	weight and report in greater than 2# in or When interviewed or Staff was not weigh was concerned abord because her torsen fluid retention) dosi Further, R472 indict breath while sitting excess fluid. R472 short of breath unless when interviewed or licensed practical in resident had an ord had not been done. When interviewed or registered nurse (Rowere not recorded or when interviewed or acting director of nuexpectation was that the daily weights as nurse, and the nurse medical record. The follow the orders as the resident could incomplications, and the facility's Weight 6/17/20, indicated wunless specifically or weights as proposed in the facility's weights as the specifically of the facility's weights as the facility's weights as the specifically of the facility's weights as the facility's weights as the facility's weights as the facility of the facility's weights as the facility of t	ncreases in weight to provider one day, or 5# in one week. on 03/29/22, at 11:29 a.m. as were swollen and she was daily morning weights, but ing her daily. R472 stated she out not getting daily weights nide (medication to reduce ng depended upon her weight. ated she was more short of which she stated was due to stated she was not normally as she was walking. on 3/29/22, at 10:57 a.m. are (LPN)-A stated the ler for daily weights, and they as ordered. on 3/30/22, at 8:25 a.m. and they as ordered. on 3/31/22, at 11:04 a.m. the are normally sets at a size of the weights daily, and did not know why. on 3/31/22, at 11:04 a.m. the are normally assistants would get as ordered, report them to the set ordered, report them to the set ordered, report them to the set ordered, and if they were not, have fluid overload, heart increased edema. at Measurement policy revised weigh each resident monthly ordered by physician to occur record the weight in the	2 830			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00979	B. WING		03/3	1/2022
	PROVIDER OR SUPPLIER	VALLEY 14650 GA	RRETT AVE			
		APPLE VA	ALLEY, MN	55124		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 9	2 830			
	Hoffman, Sherry					
	cognitively intact, di extensive assistano	MDS dated 3/23/22, identified id not reject cares, required se for most activities of daily knee replacement and ound care.				
	surgical incision on to complete a body observation. Staff w	ated 3/18/22, identified a right knee and directed staff audit and weekly skin were also to monitor for signs ealing and were to update the .				
	indicated R375 was 100 mg every 12 ho p.m. until 3/21/22, f knee joint. The orde with orthopedics as	order Report dated 3/18/22, so to take doxycycline hyclate burs; at 12:00 a.m. and 12:00 for the presence of an artificial ers also indicated to follow up instructed, however, no cluded and no follow up was				
		Inspection dated 3/18/22, of R375's surgical incision.				
		/ Inspection dated 3/24/22, of R375's surgical incision.				
	scale used to meas pressure injuries) a incomplete and lack assessment or obs- for pressure injury of	sive Skin Risk with Braden (a sure a resident's risk for ssessment dated 3/25/22, was ked a Braden score or any ervation regarding R375's risk other than R375's need for Ls. The "surgical wound" box				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPLI						
		00979	B. WING		03/3	1/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AUGUST	ANA HCC OF APPLE	VΔIIFY	RRETT AVE			
	OURANA DV OTA		ALLEY, MN		<u></u>	1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 10	2 830			
	listed in section "Ot left unmarked.	her Skin Concerns" was also				
	-3/18/22, R375 was as instructed, howe included3/21/22, Consult w practitioner (NP)-A R375's right knee s evidence NP-A was R375's Physician N R375 complained o her right knee. The had not attended he up appointment with and that R375 did n rescheduled. The n doctor (MD)-A woul regarding the remove	rder Report indicated: to follow up with orthopedics ver, no instructions were ith onsite orthopedic nurse for a follow up regarding urgery, however, there was no not notified for a consult. ote dated 3/25/22, indicated f pain and limited mobility to note also acknowledged R375 or previously scheduled follow in the orthopedic surgical team not believe it had been ote further indicated medical d follow up with the surgeon val of R375's surgical dressing in removed since the surgery				
	at 2:13 p.m. R375 sher right total knee was discharged hor 3/10/22. R375 had at the surgical team so however, on 3/16/20 department due to ankles. R375 remains and was released to on 3/18/22, with a dunrelated to her sur arriving at the facilit medical portal (MY appointment but say	and observation on 3/28/22, stated she had a revision of replacement on 3/9/22. R375 me after her surgery on a follow up appointment with cheduled for 3/22/22, 2, she went to the emergency extreme pain in her feet and ned in the hospital for 2 days of the facility for rehabilitation, liagnosis of gouty arthritis regery. R375 stated after y, she looked at her online Chart) to verify her follow up wit had been canceled. R375 canceled the appointment and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00979	B. WING		03/3	31/2022	
NAME OF PROVIDER OR	SUPPLIER		<u> </u>	STATE, ZIP CODE	00/0	7172022	
AUGUSTANA HCC		VALLEY 14650 GA	RRETT AVE	NUE			
		APPLE V	ALLEY, MN				
PREFIX (EACH	DEFICIENC'	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
knowledg been rescondance of follow up a went to the her knee aby the fact white ban inches with extended bandage of bandage of the skin as extremely intact with of the surphandage. R375's propose. R375's propose propose and puring an R375 state removed of the surphandage. During an R375 state removed of the surphandage. During an R375 state removed of the surphandage. CC-A furth picture of the surgice.	ure who he, the followes to recomposite and had recomposite and the control of the subject of the subject and recomposite and the subject and recomposite and recomposite and the subject and recomposite and the subject	age 11 and. R375 also stated, to her ow up appointment had not R375 stated her surgical main on her right knee until the ent, however, since she never ment, the bandage was still on not been removed or assessed R375 was observed to have a proximately 6 inches long and 2 pear adhesive over top that nately one inch wider than the est, on her right knee. The stand appeared clean and dry. In gray and flaky, but otherwise eas or swelling noted. No part sion was visible under the solved dated 3/28/22, at 9:51 dressing to R375's right knee no redness, drainage, or signs of the incision was left of on 3/29/22, at 11:32 a.m. rigical bandage had been ethe previous evening. If on 3/30/22, at 11:22 a.m. lics (TCO) care coordinator ause R375's follow up the surgical team had been ould have been notified and ision should have been notified and ision should have been of infection and dehiscence. If she wanted the staff to take a surgical incision and send it to so they could assess it before ome that afternoon.	2 830				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00979	B. WING		03/3	31/2022
	PROVIDER OR SUPPLIER	VALLEY 14650 GA	DRESS, CITY, S RRETT AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 830	During an interview Fairview surgical Cappointment on 3/2 canceled by the factor operative follow up team would not have been admitted her knee surgery, Fassessed by the factor operative facility physician's as she saw R375 on 3 R375's knee becaus till covering it. PA-discharged to her properative many of R375's possivere missed by the had been admitted her knee surgery, Fassessed by the factor of the fac	on 3/30/22, at 12:18 p.m. C-B stated R375's follow up 2/22, would have been illity because the post is important and the surgical re canceled it. on 3/30/22, at 8:57 a.m. resistant (PA)-A stated when //21/22, she did not assess se the surgical bandage was A stated because R375 was rivate home after surgery, rest-op and discharge orders facility. PA-A stated if R375 to the facility immediately after ray would have been resisted she did not know who resisted she did not sessessed resisted she did not know who resisted she did not know who resisted she incision site assessed resisted she did not know who resisted she incision site assessed resisted she did not know who resisted she did not	2 830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE COMP	SURVEY	
		00979	B. WING		03/3	31/2022
NAME OF I	PROVIDER OR SUPPLIER	STREE	TADDRESS, CITY,	STATE, ZIP CODE		
AUGUST	ANA HCC OF APPLE	VΔIIFY	GARRETT AVE E VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 13	2 830			
	indicated licensed shead-to-toe inspect admission to the far findings in the resid record (EMR). The treat existing skin complemented based assessment and coassistants (NAs) via staff were to comple of the resident's ski the EMR. NAs were during routine cares licensed nurse. Residented in the alteration's location	egrity policy dated 2/4/21, staff would perform a ion of their skin upon cility and document their lent's electronic medical care plan and interventions oncerns would be don the resident's skin risk ammunicated to the nursing a assignment sheets. License te a head-to-toe assessment and document findings in the to perform daily skin checks and report concerns a sident skin alterations were the EMR and include the , a description of the skin, um), surrounding the wound.	sed ent as			
21375	The director of nurs review and /or revise ensure timely assess developed medical positioning. The DC monitoring systems compliance and repassurance committed recommendations. TIME PERIOD FOR (21) days.	oort the results to the quality ee for further R CORRECTION: Twenty-o	o ir op			
21375	MN Rule 4658.0800 Program	Subp. 1 Infection Control;	21375			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00979	B. WING		03/3	1/2022
	PROVIDER OR SUPPLIER	VALLEY 14650 GA	DRESS, CITY, S RRETT AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21375	Subpart 1. Infection home must establist control program destantary environment	n control program. A nursing h and maintain an infection signed to provide a safe and nt.	21375			
	by: Based on observati review the facility fa appropriate persona and performed hand (R68, R120) on ent Clostridium difficile large intestine caus that can be serious highly contagious).	ent is not met as evidenced on, interview, and record illed to ensure staff wore al protective equipment (PPE) d hygiene for 2 of 2 residents eric, contact precautions for (C-Diff-an infection of the ed by long-term antibiotic use and life threatening, that is This had the potential to effect the unit being cared for by the				
	2/22/22, indicated F deficits with diagnosseptic shock (an infatroughout the body chronic kidney dise anticoagulant use (Clostridium difficile assistance of two stand extensive assistance of two stands are assessment and R68's Care Area As 2/22/22, indicated Floss, urinary inconti	nimum Data Set (MDS) dated R68 had moderate cognitive ses of severe sepsis with fection that has spread y and is life threatening), ase, morbid obesity, blood thinners), and R68 required extensive staff for bed mobility, toileting, stance of one staff for personal occurred once or twice during d required two staff.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	D PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:	<u> </u>	COMP	LETED
			B. WING			
		00979	b. WING		03/3	1/2022
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
AUGUST	ANA HCC OF APPLE	VALLEY	RRETT AVE			
	T		ALLEY, MN	T		ı
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21375	Continued From pa	age 15	21375			
	indicated R68's sto positive for C-Diff a was placed on cont to wash his hands u hand sanitizer.	e dated 3/27/22, at 4:08 p.m. ol sample was reported at 1:30 p.m. on 3/27/22. R68 tact precautions and advised using soap and water and not				
	R120 was cognitive urinary tract infection with hypoxia (low or	MDS dated 3/19/22, indicated ely intact with diagnoses of on, acute respiratory failure xygen), chronic kidney disease plant, and seizures.				
	on 3/28/22, from 12 enteric transmission sign was posted on R68 (window side). The sign indicated must: clean their hagown and gloves at everyone was to wawater. Nursing assi 121 wearing a surg gloves as indicated R68 was recently difficile. NA-E state indicated gowns an entering the resider nurse and had learn when providing directly (SW)-A then entered tray wearing a surg but no gown or glover tray on his bedside to the left side of his face the television. wheelchair on the resident resident resident of the resident	s observation and interviews 2:36 p.m. to 12:50 p.m. an n-based precautions (TBP) in the door to room 121 where and R120 (door side) resided. everyone entering the room ands with sanitizer and wear a nd, upon exiting the room, ash their hands with soap and istant (NA)-E entered room gical mask, but no gown or all by the TBP sign. NA-E stated liagnosed with Clostridium ed, although the TBP sign and gloves were required upon and they were only required ect cares. Social worker ed room 121 carrying a meal gical mask and eye protection wes. SW-A placed R120's meal table and positioned the table as bed, towards R68's bed, to R68 was sitting in his right side of his bed toward acing the television. SW-A then is wheelchair, behind his				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
00979		B. WING		03/3	31/2022	
	PROVIDER OR SUPPLIER	VALLEY 14650 GA	DRESS, CITY, S RRETT AVE		-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21375	bedtable to the left were now sitting ne television, less thar pushed the curtain residents back far ecould view each off not their faces. SW she did not know whand sanitizer wher and gowns were on direct care such as resident in their who not usually deliver read the TBP sign powers. SW-A was unaware her hands upon exi was supposed to wink. During a continuous 3/28/22, at 4:53 p.n stated R68 had beed due to his recent diclear plastic bag of previous bed and the was covered with powers and bottles. The TE from the door leaving remained contaminentering the room of infected and spread R68's items and be personal protective gowns and gloves. R68's room without up R68's walker, gaup items from the flof clothing from the	ge 16 of his bed. R68 and R120 xt to each other facing the hard three feet apart. SW-A divider between the two enough that R68 and R120 her's meal trays, and legs but -A stated R68 was on TBP but hy. SW-A stated she used hashe left the room and gloves hashe left the room and shed if hashe sident meals and had not be room to entering room 121. He of the requirement to washe hashe them in the residents' so observation and interview on hashe room and asked if she hashe them in the residents' so observation and interview on hashe room and asked if she hashe them in the residents' so observation and interview on hashe room and asked if she hashe them in the residents' so observation and interview on hashe room and asked if she hashe them in the residents' so observation and interview on hashe room and asked if she hashe them in the residents' so observation and interview on hashe room and asked if she hashe them in the residents' so observation and interview on hashe room and asked if she hashe the room hashe room hashe room and she did hashe room hash	21375			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00979	B. WING		03/3	1/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AUGUST	AUGUSTANA HCC OF APPLE VALLEY 14650 C APPLE					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21375	should have worn a touching R68's pers brush against her of At 5:28 p.m. R68's the windowsill in R6 the items were conducted. During an observat at 11:42 a.m. nursing of R68's new room removing gloves froballed the gloves in gait belt as she wall stated she had gon towel up off the flood gown because the not providing cares occurred to her that contaminated. During observation 1:10 p.m. R68's old the bed was made, seen, remained as and a green sling untransferring resident such as a bed and door. Maintenance and explained he wowindow. MT-A then moved it out of his entered the room a and sling belonged brought to R68's new MT-A stated he was to R68 and were possible.	a gown and gloves when sonal items as they could lothing and contaminate them. personal items remained on 68's room with no indication taminated. ion and interview on 3/29/22, and assistant (NA)-D came out carrying a gait belt and om her hands. NA-D then her hands while carrying the ked down the hallway. NA-D e into R68's room to pick a or but had not worn gloves or a towel was clean, and she was to R68. NA-D stated it had not the towel could have been and interview on 3/29/22, at a room had been cleaned and The dumbbell previously the only item on the windowsill sed with a hydraulic lift when at from one surface to another toilet, hung on the bathroom (MT)-A entered R68's room as going to be working on the picked up the dumbbell and way on the windowsill. NA-E and confirmed the dumbbell to R68 and should have been as wroom the previous day. It is unaware the items belonged ossibly contaminated.	21375			
		nist (IP) stated staff were to n, masks, and gloves when				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMI	(X3) DATE SURVEY COMPLETED	
00979 B. WING 03/3	31/2022	
NAME OF PROVIDER OR SUPPLIER AUGUSTANA HCC OF APPLE VALLEY STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124		
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
entering a resident's room who is on enteric TBP for C-Diff. Staff should have used hand sanitizer before entering the room and donning gloves, remove and dispose of the gloves in the resident's room, and wash their hands in the resident's room, and wash their hands in the resident's room, and wash their hands in the resident sink prior to leaving the room. Staff were to wear gowns when providing direct care or contacting the environment of a resident on TBP or their roommate, including wheelchairs and bed tables. IP stated SW-A should have worn a gown and gloves when she assisted R120 and SW-A should have washed her hands prior to leaving R68's room to avoid cross-contamination. IP also stated the dumbbell and sling should have been removed prior to R68's area being cleaned to avoid possible contamination. During an interview on 3/31/22, at 12:00 p.m. the interim director of nursing (DON) stated masks, eye protection, and gloves were to be worn prior to entering rooms of residents on TBP to avoid cross contamination of residents or staff who were not infected. The DON further stated the staff were to follow the facility policy. The facility Clostridium Difficile Infection (CDI) policy dated 10/26/21, indicated C-Diff spores could live on surfaces in the environment for months and staff could spread the bacteria through hand contact after touching a contaminated surface. Gloves were to be worn prior to entering a resident's room with known or suspected CDI and removed prior to exiting the room. Gowns were to be worn while providing direct care or when coming into contact with the resident's environment.		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` '		(X3) DATE SURVEY COMPLETED	
ANDILAN	OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COIVII	LLILD
		00979	B. WING		03/3	1/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
AUGUST	ANA HCC OF APPLE	VALLEY	RRETT AVE ALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21375	review applicable p ensure proper donr developed medical disease care. The I review applicable p ensure the timely a vaccinations for the could then educate polices and develop systems to ensure report the results to committee for further	olicies and procedures to hing and doffing of PPE for conditions and/or infectious DON or designee could also olicies and procedures to dministration of recommended resident population. They the direct care staff on these or and/or implement monitoring ongoing compliance and the quality assurance er recommendations. R CORRECTION: Twenty-one	21375			
21665	A nursing home must functional, comfortate environment, allowing personal belonging. This MN Requirements by: Based on observation review, the facility from pump, pole and base condition for 2 of 2 reviewed for tube for tube for the facility of the faci	D Physical Environment Just provide a safe, clean, able, and homelike physical ing the resident to use is to the extent possible. Just provide a safe, clean, able, and homelike physical ing the resident to use is to the extent possible. Just provide and to use is to the extent possible. Just provide and document ailed to ensure a tube feeding is was cleaned and in sanitary residents (R12 and R33) is eding. Just provide a safe, clean, able, clean to use is to use it is not met as evidenced in the physical indicated R12 cognition was R12's diagnoses included and had 51% or more of total	21665			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00979	B. WING		03/3	31/2022
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
AUGUSTANA HCC OF APPLE VALLEY			RRETT AVE ALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21665	calories received the feeding during the experiod. R33's quarterly MD R33's cognition was diagnoses included R33 had a feeding total calories receive feeding during the experiod. During observation was lying in bed. Reperiod. During observation was lying in bed. Reperiod and a moderate amount and a moderate amount and the feeding equipation have the dried tapump, pole and bases.	rough parenteral or tube entire seven day look back S dated 1/18/22, indicated as severely impaired. R33's malnutrition and dysphagia. Tube and had 51% or more of ed through parenteral or tube entire seven day look back on 3/29/22, at 12:04 p.m. R12 12's tube feeding equipment fount of dried tan colored on the pump, the pole and the on 3/30/22, at 8:51 a.m. R12's ment was observed to continue in substance present on the se. R12's tube feeding pump was at the bedside. R12 had	21665			
	a container of tan ce to the pump with the open to air with smalliquid in the tip During observation was lying in bed. Rehad a moderate amount of the pole. During observation R33's tube feeding continue to have the on the pump, pole apump wasn't running to the total results of the pump.	olored liquid formula attached e tubing hanging and the tip all amount of tan colored dried on 3/29/22, at 12:06 p.m. R33 33's tube feeding equipment tount of dried tan colored on the pump, the pole and the on 3/20/22, at 8:52 a.m. equipment was observed to e dried tan substance present and base. R33's tube feeding g and was at the bedside.				

Minnesota Department of Health

STATE FORM F8UY11 If continuation sheet 21 of 23

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00979	B. WING		03/3	31/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	,	
		14650 GA	RRETT AVE			
AUGUSTANA HCC OF APPLE VALLEY APPLE			ALLEY, MN	55124		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21665	Continued From pa	ge 21	21665			
		np with the tubing hanging and with small amount of tan in the tip.				
	registered nurse (R of which staff meml equipment. RN-A vo R12's and R33's tul	3/30/22, at 10:33 a.m. N)-A stated she was unaware pers cleaned resident erified the current condition of pe feeding equipment was led like the dried formula had nent for a while.				
	nursing assistant (N schedule for cleaning Further, NA-A state cleaned when it is not verified the current tube feeding equipment	3/30/22, at 10:33 a.m. NA)-A stated there wasn't a ng resident equipment. d resident equipment is noticed to be "dirty". NA-A condition of R12's and R33's ment looked like the dried on the equipment for a while.				
	registered nurse ma wasn't a schedule for equipment and was cleaned resident ed and R33's tube feed	3/30/22, at 10:37 a.m. anager (RN)-C stated there or cleaning resident a unaware what staff members quipment. RN-C verified R12's ding equipment was all have been cleaned.				
	reviewed 10/26/21, care items require I	n-disinfect equipment, last indicated noncritical resident ow level of disinfection by and after visible soiling.				
	The director of nurs	THODS OF CORRECTION: sing or designee could review and procedures on the timely g of resident care equipment;				

Minnesota Department of Health

STATE FORM F8UY11 If continuation sheet 22 of 23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	(X3) DATE SURVEY COMPLETED		
00979		B. WING		03/3	31/2022		
NAME OF PROVIDER OR SUPPLIER STREET ALL ALIGUISTANA HCC OF APPLE VALLEY 14650 GA			DRESS, CITY, S RRETT AVE ALLEY, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDITIONAL PROPERTY OF THE PROVIDER OF	SHOULD BE	(X5) COMPLETE DATE	
21665	then educate staff a systems to ensure of report the results to committee for further	ge 22 and develop monitoring ongoing compliance and the quality assurance er recommendations. R CORRECTION: Twenty-one	21665				

Minnesota Department of Health

STATE FORM F8UY11 If continuation sheet 23 of 23

PRINTED: 04/20/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED		
		245264	B. WING			03/	30/2022
	NAME OF PROVIDER OR SUPPLIER AUGUSTANA HCC OF APPLE VALLEY			1	STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ΓS	ΚO	000			
	conducted by the M	ety Code survey was linnesota Department of					
	03/30/2022. At the AUGUSTANA HEA APPLE VALLEY wa	e Fire Marshal Division on time of this survey, LTHCARE CENTER OF as found not in compliance nts for participation in					
	Medicare/Medicaid 483.70(a), Life Safe edition of National I (NFPA) 101, Life Sa	at 42 CFR, Subpart ety from Fire, and the 2012 Fire Protection Association afety Code (LSC), Chapter 19 re and the 2012 edition of					
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.					
	ONSITE REVISIT (CONDUCTED TO V SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.					
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K-	R THE FIRE SAFETY					
		IN THE E-POC PROCESS, A THE PLAN OF CORRECTION D.					
LABORATOR'	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE

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 A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
	245264	B. WING			03/	30/2022
	VALLEY		14	650 GARRETT AVENUE		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
Healthcare Fire Ins State Fire Marshal 445 Minnesota St., St. Paul, MN 55101 By email to: FM.HC.Inspections THE PLAN OF COIDEFICIENCY MUSFOLLOWING INFO. 1. A detailed desctaken or planned to 2. Address the meplace to ensure the 3. Indicate how th future performance sustained. 4. Identify who is ractions and monitor 5. The actual or p the remedy. AUGUSTANA HEALAPPLE VALLEY is a full basement.	pections Division Suite 145 -5145, OR @state.mn.us RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION: ription of the corrective action correct the deficiency. easures that will be put in deficiency does not reoccur. e facility plans to monitor to ensure solutions are responsible for the corrective ring of compliance. roposed date for completion of LTHCARE CENTER OF a three-story building, with a onstructed in 1983 and was Type II (222) construction,	K)00	DEFICIENCY)		
The building is prote	ected by a full fire sprinkler					
	Continued From particular Summary STA (EACH DEFICIENCY REGULATORY OR LESS STATE FIRE Marshall 445 Minnesota St., St. Paul, MN 55101 By email to: FM.HC.Inspections THE PLAN OF COIDEFICIENCY MUSFOLLOWING INFO. 1. A detailed descentaken or planned to 2. Address the metaplace to ensure the 3. Indicate how the future performance sustained. 4. Identify who is reactions and monitor of the remedy. AUGUSTANA HEAL APPLE VALLEY is a full basement.	PROVIDER OR SUPPLIER ANA HCC OF APPLE VALLEY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email 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. 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(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

PRINTED: 04/20/2022 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 B. WING 245264 03/30/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE **AUGUSTANA HCC OF APPLE VALLEY** APPLE VALLEY, MN 55124 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) K 000 Continued From page 2 K 000 system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 178 beds and had a census of 102 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: K 324 Cooking Facilities K 324 SS=E 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, * 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

(X2) MULTIPLE CONSTRUCTION

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245264	B. WING	<u> </u>	03/	30/2022	
	PROVIDER OR SUPPLIER	VALLEY		STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		JLD BE	(X5) COMPLETION DATE	
K 324	by: Based on observatifacility failed to proving hazards in accordated edition), Life Safety 19.3.2.5.3(9). These a patterned impact facility. Findings Include: 1. On 03/30/2022 b PM, it was revealed lower-level of the fatherapy Room their	Ige 3 NT is not met as evidenced tion and staff interview, the vide proper protection from nce with NFPA 101 (2012 y Code, sections 19.3.2.5, e deficient findings could have on the residents within the letween 09:30 AM to 02:30 d by observation that in the acility in the Occupational re was residential stove. No ct or lock-out device was	K3	324			
K 353 SS=F	2. On 03/30/2022 b PM, it was revealed lower-level of the fa Recreational Room No electrical discor observed in the imr An interview with th verified these deficit discovery. Sprinkler System - CFR(s): NFPA 101 Sprinkler System - Automatic sprinkler inspected, tested, a with NFPA 25, Stan	etween 09:30 AM to 02:30 If by observation that in the acility in the Therapy Ithere was residential stove. Innect or lock-out device was mediate area of the stove. In Maintenance Director ient findings at the time of Maintenance and Testing It and standpipe systems are and maintained in accordance dard for the Inspection, aining of Water-based Fire	Κ3	353			

	OF DEFICIENCIES OF CORRECTION	` IDENTIFICATION NUMBER: ` `		MULTIPLE CONSTRUCTION UILDING 01			(X3) DATE SURVEY COMPLETED	
		245264	B. WING			03/:	30/2022	
	PROVIDER OR SUPPLIER TANA HCC OF APPLE	VALLEY		1	TREET ADDRESS, CITY, STATE, ZIP CODE 4650 GARRETT AVENUE APPLE VALLEY, MN 55124			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 353	maintenance, inspermaintained in a sector available. a) Date sprinkler some billion of the sprinkler sprinkler sprinkler system in accordance dition), Life Safety and NFPA 25 (2011 Inspection, Testing, Water-Based Fire Food of the sprinkler sprinkler system in accordance dition), Life Safety and NFPA 25 (2011 Inspection, Testing, Water-Based Fire Food of the sprinkler sprinkler system been conducted or 2021.	s. Records of system design, ection and testing are cure location and readily system last checked system test supply source KS information on coverage for partial automatic sprinkler	K3	353				

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 04/20/2022 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G 01	COM	PLETED
		245264	B. WING _		03/	30/2022
	PROVIDER OR SUPPLIER TANA HCC OF APPLE	VALLEY		STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	
K 353	PM, it was revealed documentation that available or presentire sprinkler system completed since 20 observed on the 3rd and the full date of the fire sprinkler rist basement of the fact 3. On 03/30/2022 b PM, it was revealed 3rd floor - Dining Recabling was attached piping. 4. On 03/30/2022 b PM, it was revealed 2rd floor in RM E-21 attached to the fire 5. On 03/30/2022 b PM, it was revealed 2rd floor in E corridicabling was found a system piping. 6. On 03/30/2022 b PM, it was revealed 2rd floor in E corridicabling was found a system piping. 6. On 03/30/2022 b PM, it was revealed Lower Level in the 1 found attached to the found attached to the floor - East corridor fire sprinkler system 8. On 03/30/2022 b PM, it was revealed floor - East corridor fire sprinkler system 8. On 03/30/2022 b Son 0	I by a review of available no documentation was ted for review to confirm that a n 5 year inspection had been n 16. (The year 2016 was defloor fire sprinkler riser gage, 10/05/2016 was observed on the gage located in the cility.) etween 09:30 AM to 02:30 I by observation that on the com - Mechanical Room, and to the fire sprinkler system observation that on the com sprinkler system piping. etween 09:30 AM to 02:30 I by observation that on the company of the celling that attached to the fire sprinkler sprinkler system of above the celling that attached to the fire sprinkler etween 09:30 AM to 02:30 I by observation that on the company of the celling that attached to the fire sprinkler system piping. etween 09:30 AM to 02:30 I by observation that on the Boiler Room, cabling was the fire sprinkler system piping.	K 35	3		

(X2) MULTIPLE CONSTRUCTION

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01		(X3) DATE SURVEY COMPLETED		
	245264	B. WING			03/3	30/2022
	VALLEY		14	4650 GARRETT AVENUE	•	
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
floor in the Dining Rheads in the vicinity covered with a foreign of the property of the prope	Room Area that fire sprinkler of the serving kitchen were ign substance. etween 09:30 AM to 02:30 by observation on the Lower y Washing and Dryer Areas, eads exhibited signs of between 09:30 AM to 02:30 by observation on the Lower in Dishwashing Area that fire	K	353			
verified these deficit discovery. Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the signal and simulation conditions. Fire drill unexpected times used to the signal and simulation conditions. Fire drill unexpected times used to the signal and simulation conditions. Fire drill unexpected times used to the signal and simulation conditions. Fire drill unexpected times used to the signal and simulation and signal	ent findings at the time of e transmission of a fire alarm on of emergency fire s are held at expected and inder varying conditions, at ach shift. The staff is familiar d is aware that drills are part of Where drills are conducted nd 6:00 AM, a coded y be used instead of audible 1.7.1.7 NT is not met as evidenced int review and staff interview,	Κī	712			
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa floor in the Dining F heads in the vicinity covered with a fore 9. On 03/30/2022 b PM, it was revealed Level in the Laundr that fire sprinkler he oxidation. 10. On 03/30/2022 PM, it was revealed Level in the Kitcher sprinkler heads exh An interview with th verified these deficit discovery. Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include th signal and simulation conditions. Fire drill unexpected times us least quarterly on exit with procedures and established routine. between 9:00 PM as announcement may alarms. 19.7.1.4 through 19 This REQUIREMEN by: Based on document the facility failed to	ANA HCC OF APPLE VALLEY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 floor in the Dining Room Area that fire sprinkler heads in the vicinity of the serving kitchen were covered with a foreign substance. 9. On 03/30/2022 between 09:30 AM to 02:30 PM, it was revealed by observation on the Lower Level in the Laundry Washing and Dryer Areas, that fire sprinkler heads exhibited signs of oxidation. 10. On 03/30/2022 between 09:30 AM to 02:30 PM, it was revealed by observation on the Lower Level in the Kitchen Dishwashing Area that fire sprinkler heads exhibited signs of oxidation. An interview with the Maintenance Director verified these deficient findings at the time of discovery. Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced	ROVIDER OR SUPPLIER ANA HCC OF APPLE VALLEY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 floor in the Dining Room Area that fire sprinkler heads in the vicinity of the serving kitchen were covered with a foreign substance. 9. On 03/30/2022 between 09:30 AM to 02:30 PM, it was revealed by observation on the Lower Level in the Laundry Washing and Dryer Areas, that fire sprinkler heads exhibited signs of oxidation. 10. On 03/30/2022 between 09:30 AM to 02:30 PM, it was revealed by observation on the Lower Level in the Kitchen Dishwashing Area that fire sprinkler heads exhibited signs of oxidation. An interview with the Maintenance Director verified these deficient findings at the time of discovery. 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WING 245264 ROVIDER OR SUPPLIER ANA HCC OF APPLE VALLEY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 floor in the Dining Room Area that fire sprinkler heads in the vicinity of the serving kitchen were covered with a foreign substance. 9. On 03/30/2022 between 09:30 AM to 02:30 PM, it was revealed by observation on the Lower Level in the Laundry Washing and Dryer Areas, that fire sprinkler heads exhibited signs of oxidation. 10. On 03/30/2022 between 09:30 AM to 02:30 PM, it was revealed by observation on the Lower Level in the Kitchen Dishwashing Area that fire sprinkler heads exhibited signs of oxidation. An interview with the Maintenance Director verified these deficient findings at the time of discovery. Fire Drills CFR(s): NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to conduct fire drills in	ROVIDER OR SUPPLIER ANA HCC OF APPLE VALLEY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST SEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 floor in the Dining Room Area that fire sprinkler heads in the vicinity of the serving kitchen were covered with a foreign substance. 9. On 03/30/2022 between 09:30 AM to 02:30 PM, it was revealed by observation on the Lower Level in the Laundry Washing and Dryer Areas, that fire sprinkler heads exhibited signs of oxidation. 10. On 03/30/2022 between 09:30 AM to 02:30 PM, it was revealed by observation on the Lower Level in the Kitchen Dishwashing Area that fire sprinkler heads exhibited signs of oxidation. An interview with the Maintenance Director verified these deficient findings at the time of discovery. Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 DM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to conduct free drills in

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01		(X3) DATE SURVEY COMPLETED		
		245264	B. WING			03/30/2022	
	PROVIDER OR SUPPLIER ANA HCC OF APPLE	VALLEY		1	TREET ADDRESS, CITY, STATE, ZIP CODE 4650 GARRETT AVENUE IPPLE VALLEY, MN 55124		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 712	4.7.2, and 4.7.6. T	ige 7 ections 19.7.1.4, 19.7.1.6, hese deficient findings could impact on the residents within	K 7	'12			
	PM, it was revealed documentation that available or present	etween 09:30 AM to 02:30 If by a review of available no documentation was ted for review to confirm that a onducted for 2nd shift - 3rd					
	PM, it was revealed that the that fire dril revealed a lack of r dates on which drill a. 1st shift - 1st ar conducted on the s b. 1st shift - 3rd ar conducted on the s c. 11 of 12 docum	etween 09:30 AM to 02:30 If during documentation review I reports presented for review andomness in the calendar is were conducted. Ind 2rd quarter drills were ame calendar date - 31st and 4th quarter drills were ame calendar date - 30th ented fire drills were st week of each respective					
K 914 SS=C	verified this deficier discovery.	e Maintenance Director nt finding at the time of - Maintenance and Testing	KS)14			
	Hospital-grade recellocations and where anesthesia is admir	- Maintenance and Testing eptacles at patient bed e deep sedation or general nistered, are tested after initial ment or servicing. Additional					

AND DIAN OF CORRECTION IN INDENTIFICATION NUMBER:		A. BUILDII	IPLE CONSTRUCTION NG 01		COMPLETED	
		245264	B. WING _		03/	30/2022
	PROVIDER OR SUPPLIER TANA HCC OF APPLE	VALLEY		STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
K 914	testing is performed documented perfor listed as hospital-gratested at intervals risolation monitors (intervals of less that actuating the LIM to which activates bot LIM circuits with au manual test is performed to 12 months 6.3.3.3.2 after any relectric distribution maintained of requirepairs or modificat area tested, and reading to 12 months 6.3.4 (NFPA 99). This REQUIREMENT by: Based on a review and staff interview, information associatesting in resident redition), Health Car 6.3.3.2, 6.3.4.1.4, 6 finding could have a residents within the Findings include: On 03/30/2022 betwas revealed by a redocumentation that for review did not in inspections of reside which they were contacted.	d at intervals defined by mance data. Receptacles not rade at these locations are not exceeding 12 months. Line LIM), if installed, are tested at an or equal to 1 month by lest switch per 6.3.2.6.3.6, the visual and audible alarm. For tomated self-testing, this formed at intervals less than or LIM circuits are tested per repair or renovation to the system. Records are red tests and associated ions, containing date, room or sults. NT is not met as evidenced of available documentation the facility failed to record ated to electrical receptacle dooms per NFPA 99 (2012 re Facilities Code, section(s) 1.3.4.2.1.2. This deficient a widespread impact on the facility. ween 09:30 AM to 02:30 PM, it review of available the documentation presented dentify who completed the lent rooms and the dates on	K 9 ⁻			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
		245264	B. WING		03/:	30/2022
	PROVIDER OR SUPPLIER	VALLEY		STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 914		ge 9	K 914			
K 918 SS=F		- Essential Electric Syste	K 918			
	Maintenance and To The generator or of and associated equations are riterion is not metal process shall be processed shall be processed shall be processed and the transfer switches are with NFPA 110. Generator sets are under load 30 minuted and 30 minuted and intervals, and emonths for 4 continuated conditions in the conditions in the conditions of all EES I competent personnes accordance with NF circuit breakers are program for periodic components is estal manufacturer requiremaintenance and the circuits are marked separate from norm the possibility of da source is a design of installations.	ther alternate power source sipment is capable of supplying econds. If the 10-second during the monthly test, a covided to annually confirm this exafety and critical branches. Setting of the generator and reperformed in accordance inspected weekly, exercised tes 12 times a year in 20-40 exercised once every 36 every				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILE		LE CONSTRUCTION 01		E SURVEY IPLETED
		245264	B. WING			03/	30/2022
	PROVIDER OR SUPPLIER TANA HCC OF APPLE	VALLEY		1	STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
K 918	This REQUIREMENT by: Based on observated documentation, and failed to maintain the systems and comple edition), Health Care 6.4.1.1.13, and NFF Standard for Emergy Systems, sections 6.5.5.2(4), NFPA 70 Electrical Code, section (1), 110.26(C)(1). Thave a widespread the facility. Findings include: 1. On 03/30/2022 b PM, it was revealed the facility, that the was located on an eroom. Access to the was fully obstructed 2. On 03/30/2022 b PM, it was revealed recent vendor annual Cummins 03/15/202 the battery age was years. 3. On 03/30/2022 b PM, it was revealed recent vendor annual Cummins 03/15/202 the battery age was years. 3. On 03/30/2022 b PM, it was revealed the facility that the goanel located in the Station did not funcil to could not be confident to the confident of the could not be confident to the con	ge 10 NT is not met as evidenced ion, a review of available d staff interview, the facility ie emergency power supply onents per NFPA 99 (2012 e Facilities Code, section PA 110 (2010 edition), gency and Standby Power 5.6.4.5.1, 8.3, 5.6.5.6, 5.6.6, 0 (2011 edition), National otions 110.1, 110.26, 110.26(A) hese deficient findings could impact on the residents within etween 09:30 AM to 02:30 I during the walk-through of generator emergency stop d at the time of inspection. etween 09:30 AM to 02:30 I by a review of the most al on-site inspection report (21), that the technician noted at that time in excess of 2 etween 09:30 AM to 02:30 I during the walk-through of generator remote annunciator at that time in excess of 2 etween 09:30 AM to 02:30 I during the walk-through of generator remote annunciator area of the 1st floor Nursed tion or illuminate upon testing. irmed that the generator panel was operational	K	918			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 B. WING 245264 03/30/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE **AUGUSTANA HCC OF APPLE VALLEY** APPLE VALLEY, MN 55124 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) K 918 Continued From page 11 K 918 An interview with the Maintenance Director verified these deficient findings at the time of discovery. Electrical Equipment - Power Cords and Extens K 920 K 920 CFR(s): NFPA 101 SS=F Electrical Equipment - Power Cords and **Extension Cords** Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced Based on observation and staff interview, the facility failed to properly manage the implementation and usage of power strips in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4 and

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245264	B. WING		03/3	0/2022	
	PROVIDER OR SUPPLIER	VALLEY		STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
K 920	sections 400-8, 590	ge 12 tion), National Electrical Code, 0.3(D). These deficient findings pread impact on the residents	ΚS	920			
	PM, it was revealed	etween 09:30 AM to 02:30 I during the walk-through of xtension cord was in use on m N-337					
	PM, it was revealed the facility that appl power strips in the t Room E-305; 2nd fi	etween 09:30 AM to 02:30 If during the walk-through of iances were connected to following locations: 3rd floor in loor in the Dining Room; 2nd er Level in the Payroll Office; Admin Office					
	PM, it was revealed the facility that pow	etween 09:30 AM to 02:30 I during the walk-through of er strips were daisy-chained wer Level in Office S-1					
K 923 SS=C	verified these finding	e Maintenance Director gs at the time of discovery. ylinder and Container Storag	K 9	923			
	Greater than or equ Storage locations a ventilated in accord 5.1.3.3.3. >300 but <3,000 cu Storage locations a	ylinder and Container Storage ual to 3,000 cubic feet re designed, constructed, and lance with 5.1.3.3.2 and bic feet re outdoors in an enclosure or interior space of non- or					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
		245264	B. WING		03/:	30/2022
	PROVIDER OR SUPPLIER ANA HCC OF APPLE	VALLEY	1	STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 923	limited- combustible gates outdoors) that gases are not store separated from consprinklered) or encland noncombustible consprinklered) or encland noncombustible consprinklered in a single smoke of cylinders available for care areas with an or equal to 300 cubstored in an encloss handled with precard a precautionary signer each door or gate of where the sign incluminimum "CAUTIO STORED WITHIN I Storage is planned of which they are recylinders. When faintegral pressure gas considered empty is are marked to avoid in the open are profit. 3.1, 11.3.2, 11.3. This REQUIREMENT by: Based on observating facility failed to main storage and manage edition), Health Carson 13.2.3, 11.3.4, 11.55 (2010 edition), Cryogenic Fluids Carson 14.1.1.55 (2010 edition), Cryogenic Fluids Carson 14.1.55 (2010 edition)	e construction, with door (or t can be secured. Oxidizing d with flammables, and are abustibles by 20 feet (5 feet if osed in a cabinet of a cabinet	K 923			

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(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 B. WING 245264 03/30/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE **AUGUSTANA HCC OF APPLE VALLEY** APPLE VALLEY, MN 55124 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) K 923 Continued From page 14 K 923 could have a patterned impact on the residents within the facility. Findings include: On 03/30/2022 between 09:30 AM to 02:30 PM, it was revealed by observation that 3rd floor -N-329 and 2nd floor N-229, Med Gas Rooms were found unsecured. An interview with the Maintenance Director verified this deficient finding at the time of discovery Gas Equipment - Qualifications and Training K 926 K 926 SS=F CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based a review of available documentation review and staff interview, the facility failed to provide information related to onboard training and annual refresher training as medical gas and equipment as it related to NFPA 99 (2012 edition), Health Care Facilities Code, section 11.5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 (X3) DATE COMP			
		245264	B. WING _		03/	30/2022
	PROVIDER OR SUPPLIER	VALLEY		STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 926	On 03/30/2022 between severaled by a redocumentation that available or present the facility has in platraining program for and annual refreshed. An interview with the	veen 09:30 AM to 02:30 PM, it	K 920			