



Protecting, Maintaining and Improving the Health of All Minnesota

Electronically delivered
August 24, 2020

Administrator
Ridgeview Lesueur Long Term Care And Rehab Center
621 South 4th Street
Le Sueur, MN 56058

RE: CCN: 245416
Cycle Start Date: August 3, 2020

Dear Administrator:

On August 3, 2020, a survey was completed at your facility by the Minnesota Department(s) of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby corrections are not required.

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action were taken prior to the survey, past non-compliance does not require a plan of correction (POC).

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 listed below to the CMS Region V Office for imposition: You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$10,483; 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.

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

Facility Name()]

August 24, 2020

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DEPARTMENT CONTACT

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

**Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Phone: 651-201-3784**

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**

Facility Name()

August 24, 2020

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,



Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/14/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245416	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/03/2020
NAME OF PROVIDER OR SUPPLIER MINNESOTA VALLEY HEALTH CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 621 SOUTH 4TH STREET LE SUEUR, MN 56058		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS On 8/3/20, an abbreviated standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was not in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. Complaint #H5416012C was substantiated at F689, for past non-compliance. Although the provider had implemented corrective action prior to survey, harm or immediate jeopardy was sustained prior to the correction. Although no plan of correction is required for a finding of past non-compliance, it is required the facility acknowledge receipt of the electronic documents.	F 000			
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure fall risk interventions were implemented in order to minimize the risk for falls and injury for 1 of 3 (R1) residents identified at risk for falls. This deficient practice caused actual harm to R1 who utilized a remote control to raising a lift chair to the standing position, and	F 689	Past noncompliance: no plan of correction required.	8/25/20	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/25/2020

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

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F 689	<p>Continued From page 1</p> <p>subsequently fell sustaining bilateral femur fractures. Although the resident suffered injury, the facility immediately implemented corrective action on 7/29/20 therefore, this deficient practice is being issued as past non-compliance harm.</p> <p>Findings include:</p> <p>R1's undated Face Sheet included diagnoses of cerebral infarction (stroke), hemiplegia/hemiparesis (paralysis on one side of the body) following cerebral infarction, and blindness in right eye due to stroke.</p> <p>R1's quarterly Minimum Data Set assessment dated 7/8/20, included a brief interview of mental status (BIMS) score of 9, indicating moderate cognitive impairment. The MDS also indicated R1 required extensive assistance with dressing and was totally dependent on staff for all other activities of daily living (ADLs).</p> <p>R1's care plan last reviewed/revised 7/8/20, indicated the resident was at a low risk for falls due to physical limitations from past CVA (cerebral vascular accident/stroke). Transfers with A-2 (assist of 2) and EZ lift (a type of mechanical lift). Able to use the call light appropriately. Can be resistive with toileting/repositioning. No recent falls. Interventions included: Unplug lift chair when in use.</p> <p>The Prairie Resident Care Sheets updated 8/1/20, which nursing assistants (NAs) utilized to help provide resident care, included: UNPLUG RECLINER when in use for R1.</p> <p>An undated Prairie List #2 sheet utilized by the</p>	F 689			

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F 689	<p>Continued From page 2</p> <p>NAs to refer to and write notes on also included for R1: Unplug recliner when in use.</p> <p>A State Agency (SA) report submitted 7/29/20, at 4:21 a.m. indicated on 7/28/20, at 11:45 p.m. R1 was using her lift chair, elevated it up resulting in her falling forward onto the ground. The report further indicated R1 was sent to the Emergency Room (ER) and was diagnosed with a broken fibula. The note included, "Resident son is planning on removing the chair and replacing it with a normal recliner to prevent this in the future."</p> <p>An additional report submitted to SA on 7/29/20, at 13:07 (1:07 p.m.) indicated: Writer resubmitting into appropriate system. Per [RN-A]: Resident was observed on the floor in her room at 11:45 p.m. Resident was face down partially laying on right side. Resident unable to state what had happened but it was noted that her recliner chair was plugged in when it is supposed to be unplugged when resident is sitting in her chair. Resident was able to move all extremities, but appeared very painful. Resident was helped back to bed with EZ lift and three assist. Tylenol was given and ice pack applied to left knee area due to noted swelling. Resident had some bruising starting to form around her left eye. Uncertain as to where any other injury as resident unable to communicate clearly. Resident's son was informed of incident. Resident was sent to Ridgeview Le Sueur Medical Center for further evaluation. It was determined around 2:19 a.m. that resident obtained a fractured femur and was transported to Methodist Hospital in St. Louis Park. Facility cameras were reviewed by DON (director of nursing) prior to resident's fall to determine last staff members to be in resident's</p>	F 689			

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F 689	<p>Continued From page 3</p> <p>room. The last seen staff members in resident's room prior to fall were NAR's [NA-A] and [NA-B]. DON has reached out to both NAR's to further interview and investigate situation. Resident currently has a bed hold. Action taken to protect the resident: Resident's electric lift chair removed and manual recliner placed in resident room. Education will be provided to staff regarding following resident care guides.</p> <p>When interviewed on 8/3/20, at 10:10 a.m. NA-B confirmed having worked the evening shift on 7/28/20, and verified having assisted with transferring R1 into her recliner after the resident's bedtime cares. NA-B confirmed at the end of his shift on 7/28/20, R1 was still in the recliner. NA-B stated, "[R1] is a full assist and would not be able to self transfer or ambulate on her own, though could respond yes or no to questions." NA-B confirmed when the resident was in the recliner it was supposed to be unplugged. NA-B was unable to verify whether R1's recliner was unplugged the evening of 7/28/20, but had assumed it was unplugged because she was sitting in it. NA-B was unable to state whether R1 could use the recliner's remote control independently.</p> <p>When interviewed on 8/3/20, at 10:37 a.m. NA-C confirmed having worked the shift when R1 fell on 7/28/20. NA-C confirmed finding R1 on the floor in her room after the fall, stating she'd been walking down the hall to answer a call light, then heard a clang and some yelling. NA-C said when she'd gone to investigate, R1 was on the floor in her room with the recliner all the way up which meant it had been plugged in, when it wasn't supposed to be. NA-C further stated, "It says it right on her care plan". NA-C confirmed it was</p>	F 689			

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F 689	<p>Continued From page 4</p> <p>the responsibility of the staff that put the resident into the recliner to make sure it was unplugged.</p> <p>When interviewed on 8/3/20, at 10:48 a.m. NA-A confirmed she and NA-B had transferred R1 into her recliner the evening of 7/28/20. NA-A confirmed R1 had an electric lift chair recliner but could not confirm or deny if they had unplugged the recliner when R1 was transferred into the recliner. NA-A stated there was another resident on that unit who also needed to have their recliner unplugged while in it. NA-A stated there was one time she'd left the other resident's recliner plugged in and a co-worker had informed her the recliner needed to be unplugged when the resident was in it. NA-A stated she wasn't totally sure if R1 had the same criteria. NA-A stated she was new and on 7/28/20 had been working with another NA who was new. NA-A confirmed having training related to resident care plans, and also verified having access to resident care plans to review interventions. NA-A reported having worked at the facility for 2 months.</p> <p>When interviewed on 8/3/20, at 11:35 a.m. NA-D stated there was a communication binder at the nurses' desk which included the resident care sheets for NAs to refer to. NA-D confirmed when R1 was in her recliner it was to be unplugged.</p> <p>When interviewed on 8/3/20, at 11:50 a.m. registered nurse (RN) case manager-B confirmed R1 was to have her recliner unplugged when seated in it. RN-B stated the NA's should all know this as it is documented on the Resident Care Sheets, as well as the Prairie List sheets that the NA's have access to. RN-B stated staff are encouraged to print out and carry with those sheets with them to refer to.</p>	F 689			

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F 689	Continued From page 5 When interviewed on 8/3/20, at 12:40 p.m. the DON confirmed NA-A and NA-B had assisted R1 into her recliner after getting the resident ready for bed the evening of 7/28/20. The DON stated it was care planned for R1's recliner to be unplugged when the resident was in it, and stated when NA-A was interviewed during the investigation, NA-A confirmed she had put R1's remote control for the recliner on the arm of the chair after transferring the resident into the recliner. The DON Stated NA-A had confirmed she had forgotten to unplug R1's recliner. The DON stated NA's received training during their general orientation on where to find resident information. The DON also stated she'd interviewed both NA-A and NA-B related to where to find resident information and they were each able to tell her the correct answer. The DON stated staff removed the electric recliner-lift chair from R1's room following the resident's fall with fractures with a plan to replace it with a manual recliner. The hospital physician progress note dated 7/31/20, included: [R1] is an 86 y.o. (year old) female WC (wheelchair)/bedbound elderly female with significant post stroke deficits (nonverbal, non ambulatory, gtube dependent for nutrition) admitted early am 7/29 this am, transferred from LaSouer [sik] hospital for LEFT distal femur fracture after a fall in her NH (nursing home). CT (computed tomography scan) of the fracture here shows an incidental RIGHT distal femur fracture as well. Found to have UTI (urinary tract infection)/frankly purulent urine when catheterized. Ortho consult appreciated. This fracture has a high risk of becoming an open fracture, repair therefore required. Higher risk	F 689			

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F 689	<p>Continued From page 6</p> <p>surgical candidate given age and comorbidities, however they are optimally manage at this time.</p> <p>A facility policy titled, Vulnerable Adult Abuse and Neglect Prevention Plan reviewed 4/23/20, included: Safety Measures K. The nursing home resident's Plan of Care includes and identifies any areas where each individual resident is vulnerable to abuse. Functional disabilities and mental incapacities are identified as potential abuse factors. All areas of vulnerability, abuse, or neglect in the Care Plan are identified by asterisk. This procedure complies with state regulations.</p> <p>A facility policy titled, Fall Prevention Plan reviewed 11/2019, includes: II Care Plan A. Resident Care Plan will be developed to address implementation of fall precautions.</p> <p>On 7/29/20, corrective action was implemented for this deficient practice. Nursing assistants were re-educated to protocols to ensure use of the resident Care Plans, and care sheets to ensure they were aware of interventions developed for implementation to meet the individual needs of residents. The facility initiated an immediate investigation and followed up with staff determined to have been involved with R1's care prior to the fall. A revision to the resident's reclining chair was made, due to the resident's assessed risk for misuse of the electric lift recliner.</p>	F 689			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 24, 2020

Administrator
Ridgeview Lesueur Long Term Care And Rehab Center
621 South 4th Street
Le Sueur, MN 56058

Re: Event ID: DSXT11

Dear Administrator:

The above facility survey was completed on August 3, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Melissa Poepping'.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00336	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/03/2020
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NAME OF PROVIDER OR SUPPLIER MINNESOTA VALLEY HEALTH CENTER INC	STREET ADDRESS, CITY, STATE, ZIP CODE 621 SOUTH 4TH STREET LE SUEUR, MN 56058
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2 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.</p> <p>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.</p> <p>INITIAL COMMENTS: On 8/3/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found IN compliance with the MN State Licensure.</p> <p>The following complaint was found to be SUBSTANTIATED: #H5416012C.</p>	2 000		

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 08/25/20
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00336	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/03/2020
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2 000	Continued From page 1 The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		