



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 14, 2023

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

RE: CCN: 245564
Cycle Start Date: March 29, 2023

Dear Administrator:

On March 29, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

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Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by June 29, 2023, (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 29, 2023, (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the

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dates specified for compliance or the imposition of remedies.

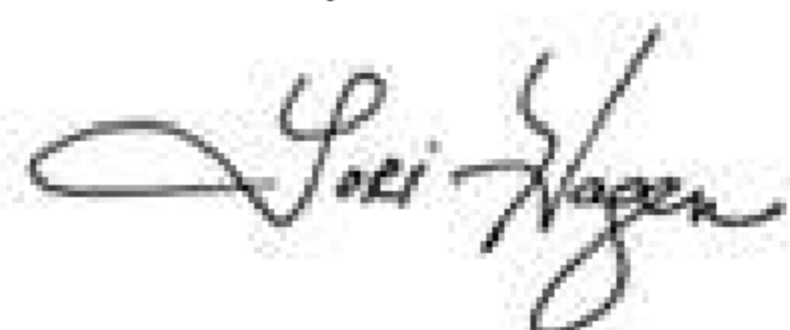
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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.

Please contact me with any questions regarding this letter.

Sincerely,

A handwritten signature in black ink that reads "Lori Hagen". The signature is written in a cursive style with a large, looping initial "L".

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us



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April 14, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: ZKPZ11

Dear Administrator:

The above facility was surveyed on March 27, 2023, through March 29, 2023, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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

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

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

Please contact me with any questions regarding this letter.

Sincerely,



Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

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

PRINTED: 04/27/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245564	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/29/2023
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NAME OF PROVIDER OR SUPPLIER BROWNS VALLEY HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 114 JEFFERSON STREET SOUTH BROWNS VALLEY, MN 56219
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(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
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E 000	<p>Initial Comments</p> <p>On 3/27/23, to 3/29/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance.</p> <p>The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.</p>	E 000		
F 000	<p>INITIAL COMMENTS</p> <p>On 3/27/23, to 3/29/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.</p> <p>The following complaints were reviewed with no deficiencies issued:</p> <p>H55649602C (MN00087675). H55649740C (MN00087677). H55649601C (MN00090435). H55649600C (MN00090511). H55649665C (MN00092117).</p> <p>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.</p>	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 04/18/2023
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER BROWNS VALLEY HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 114 JEFFERSON STREET SOUTH BROWNS VALLEY, MN 56219		
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F 000	Continued From page 1	F 000		
F 550 SS=D	<p>Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)</p> <p>§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.</p> <p>§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.</p> <p>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.</p> <p>§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without</p>	F 550		5/3/23

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F 550	<p>Continued From page 2</p> <p>interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and document review, the facility failed to maintain dignity for 1 of 1 resident (R13) who utilized an incontinent pad in her wheelchair.</p> <p>Findings Include:</p> <p>R13's significant change Minimum Data Set (MDS) dated 1/5/23, identified R13 had moderate cognitive impairment and diagnoses which included: depression, dementia and arthritis. Indicated R13 was continent of bowel and bladder and required extensive assistance with dressing, toilet use, and transfers.</p> <p>R13's care plan revised 3/28/23, identified R13 required assistance with bed mobility, bathing, transfers, and elimination. R13's care plan indicated she was at risk of bladder incontinence due to needing assistance with toileting.</p> <p>On 3/28/23, at 12:13 p.m. R13 was in the dining room with other residents and staff. R13's wheelchair had a green incontinence pad draped over the wheelchair cushion visible from all sides which hung down the front of R13's wheelchair four to six inches.</p>	F 550	<p>BVHC wants to ensure dignity is maintained for all residents. R-13s incontinent pad was replaced with original wheelchair cushion cover, that was in the laundry room.</p> <p>This could potentially happen to all residents that have a cushion in wheelchair or are incontinent. All staff will be educated to use a nonskid decorative chair covers that can and should be used in a w/c, when wheelchair cushion covers are soiled and sent to laundry.</p> <p>The DON or designee has reviewed and revised the Dignity Policy to reflect appropriate use of incontinence pads.</p> <p>The DON or designee will educate all nursing staff at the monthly meeting on 4/18/23 and 4/19/23. Education will include the updated Dignity policy and review of the scheduled audits that will be performed.</p> <p>The DON/designee will conduct audits for proper use of incontinence pads is being followed. Audits will be done 3x week for 3</p>	

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F 550	<p>Continued From page 3</p> <p>On 3/28/23, at 12:38 p.m. R13 was lying in her bed, her wheelchair was next to the bed and the green incontinence pad continued to draped over the wheelchair cushion. R13's door was open and R13's bed and wheelchair were visible from the doorway to other residents and visitors.</p> <p>During an interview on 3/28/23, at 4:51 p.m. nursing assistant (NA)-A stated R13 was continent of bowel and bladder. NA-A indicated she was not certain why R13 had an incontinent pad in her wheelchair or how long the pad had been used in R13's wheelchair.</p> <p>On 3/28/23, at 5:28 p.m. a green incontinence pad was positioned on the center of R13's bed, on top of the linen visible from the doorway. At 5:30 p.m. R13 was in the dining room seated in her wheelchair. A green incontinence pad was draped over the cushion, visible from all sides of the wheelchair and hung down in front of the wheelchair four to six inches.</p> <p>During a telephone interview on 3/29/23, at 8:06 a.m. family member (FM)-A indicated she was not aware R13 had an incontinence pad in her wheelchair and stated it was unusual since R13 was continent of bowel or bladder. FM-A stated it was not dignified for R13 to have the incontinence pad used in her wheelchair since R13 was continent.</p> <p>On 3/29/23, at 8:48 a.m. R13 was seated in her wheelchair in the dining room. A green incontinence pad was draped over the wheelchair cushion visible to other residents, staff and visitors from all sides of the wheelchair.</p> <p>During an interview on 3/29/23, at 10:31 a.m.</p>	F 550	<p>weeks, 2x week for 2 weeks, 1 x week for 4 weeks and then monthly thereafter to ensure compliance. Staff will be re-educated on an ongoing basis as needed based on the results of the audits. Findings will be brought to QAPI for review and further recommendation.</p>	

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NAME OF PROVIDER OR SUPPLIER BROWNS VALLEY HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 114 JEFFERSON STREET SOUTH BROWNS VALLEY, MN 56219		
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F 550	<p>Continued From page 4</p> <p>NA-B confirmed an incontinence pad was present in R13's wheelchair when they assisted R13 with morning cares and transferred R13 to the wheelchair that morning. NA-B stated R13 was continent. NA-B indicated it was not dignified for R13 to have the incontinence pad placed in her wheelchair.</p> <p>During an interview on 3/29/23, at 10:51 a.m. licensed practical nurse (LPN)-A indicated R13 was continent and confirmed R13's wheelchair had a green incontinence pad positioned on the wheelchair cushion. LPN-A stated it should not have been there and indicated it was a dignity issue.</p> <p>During an interview on 3/29/23, at 11:29 a.m. director of nursing (DON) confirmed she had observed R13 in the dining room in her wheelchair with the green incontinence pad draped over the wheelchair cushion. DON confirmed R13 should not have had an incontinence pad in her wheelchair as she was continent. DON stated the facility should not place incontinence pads in their wheelchairs as it was not dignified. In addition, DON indicated the incontinence pads should not have been visible on resident beds.</p> <p>Review of the facility policy titled Dignity, revised 10/23/17, identified the facility would treat each individual residing in their facility with respect and dignity. Indicated staff would provide care that could help avoid situations that could be demeaning to the residents. The policy lacked direction for the use of incontinence products, including incontinence pads.</p>	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245564	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/28/2023
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NAME OF PROVIDER OR SUPPLIER BROWNS VALLEY HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 114 JEFFERSON STREET SOUTH BROWNS VALLEY, MN 56219
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K 000	<p>INITIAL COMMENTS</p> <p>FIRE SAFETY</p> <p>The Minnesota Department of Public Safety, State Fire Marshal Division conducted an annual life safety recertification survey on 03/28/2023. At the time of this survey, Browns Valley Health Center was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code.</p> <p>Browns Valley Health Care is a 1-story building with a partial basement constructed at two different times. The original building was constructed in 1970 and was determined to be built of Type II(111) construction. In 2001 an addition was added to the north that was determined to be of Type II(111) construction. Because the original building and the addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building.</p> <p>The building is fully sprinkler protected and the sprinkler system, and has a fire alarm system with corridor smoke detection and smoke detection in spaces open to the corridors. The fire alarm system is monitored for automatic fire department notification.</p> <p>The facility has a capacity of 35 beds and had a census of 31 at the time of the survey.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ 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.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 The requirements at 42 CFR, Subpart 483.70(a), are MET.	K 000		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00668	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/29/2023
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NAME OF PROVIDER OR SUPPLIER BROWNS VALLEY HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 114 JEFFERSON STREET SOUTH BROWNS VALLEY, MN 56219
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;">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 3/27/23, to 3/29/23, a licensing survey and complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you</p>	2 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 04/18/23
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00668	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/29/2023
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2 000	<p>Continued From page 1</p> <p>have reviewed these orders and identify the date when they will be completed.</p> <p>The following complaints were reviewed with no deficiency issued, H55649602C (MN00087675). H55649740C (MN00087677). H55649601C (MN00090435). H55649600C (MN00090511). H55649665C (MN00092117).</p> <p>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction.</p> <p>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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will</p>	2 000		
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Minnesota Department of Health

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2 000	Continued From page 2 be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain dignity for 1 of 1 resident (R13) who utilized an incontinent pad in her wheelchair. Findings Include: R13's significant change Minimum Data Set (MDS) dated 1/5/23, identified R13 had moderate cognitive impairment and diagnoses which included: depression, dementia and arthritis. Indicated R13 was continent of bowel and bladder and required extensive assistance with dressing, toilet use, and transfers.	21805	Corrected	5/3/23

Minnesota Department of Health

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21805	<p>Continued From page 3</p> <p>R13's care plan revised 3/28/23, identified R13 required assistance with bed mobility, bathing, transfers, and elimination. R13's care plan indicated she was at risk of bladder incontinence due to needing assistance with toileting.</p> <p>On 3/28/23, at 12:13 p.m. R13 was in the dining room with other residents and staff. R13's wheelchair had a green incontinence pad draped over the wheelchair cushion visible from all sides which hung down the front of R13's wheelchair four to six inches.</p> <p>On 3/28/23, at 12:38 p.m. R13 was lying in her bed, her wheelchair was next to the bed and the green incontinence pad continued to draped over the wheelchair cushion. R13's door was open and R13's bed and wheelchair were visible from the doorway to other residents and visitors.</p> <p>During an interview on 3/28/23, at 4:51 p.m. nursing assistant (NA)-A stated R13 was continent of bowel and bladder. NA-A indicated she was not certain why R13 had an incontinent pad in her wheelchair or how long the pad had been used in R13's wheelchair.</p> <p>On 3/28/23, at 5:28 p.m. a green incontinence pad was positioned on the center of R13's bed, on top of the linen visible from the doorway. At 5:30 p.m. R13 was in the dining room seated in her wheelchair. A green incontinence pad was draped over the cushion, visible from all sides of the wheelchair and hung down in front of the wheelchair four to six inches.</p> <p>During a telephone interview on 3/29/23, at 8:06 a.m. family member (FM)-A indicated she was not aware R13 had an incontinence pad in her wheelchair and stated it was unusual since R13</p>	21805		
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21805	<p>Continued From page 4</p> <p>was continent of bowel or bladder. FM-A stated it was not dignified for R13 to have the incontinence pad used in her wheelchair since R13 was continent.</p> <p>On 3/29/23, at 8:48 a.m. R13 was seated in her wheelchair in the dining room. A green incontinence pad was draped over the wheelchair cushion visible to other residents, staff and visitors from all sides of the wheelchair.</p> <p>During an interview on 3/29/23, at 10:31 a.m. NA-B confirmed an incontinence pad was present in R13's wheelchair when they assisted R13 with morning cares and transferred R13 to the wheelchair that morning. NA-B stated R13 was continent. NA-B indicated it was not dignified for R13 to have the incontinence pad placed in her wheelchair.</p> <p>During an interview on 3/29/23, at 10:51 a.m. licensed practical nurse (LPN)-A indicated R13 was continent and confirmed R13's wheelchair had a green incontinence pad positioned on the wheelchair cushion. LPN-A stated it should not have been there and indicated it was a dignity issue.</p> <p>During an interview on 3/29/23, at 11:29 a.m. director of nursing (DON) confirmed she had observed R13 in the dining room in her wheelchair with the green incontinence pad draped over the wheelchair cushion. DON confirmed R13 should not have had an incontinence pad in her wheelchair as she was continent. DON stated the facility should not place incontinence pads in their wheelchairs as it was not dignified. In addition, DON indicated the incontinence pads should not have been visible on resident beds.</p>	21805		
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21805	<p>Continued From page 5</p> <p>Review of the facility policy titled Dignity, revised 10/23/17, identified the facility would treat each individual residing in their facility with respect and dignity. Indicated staff would provide care that could help avoid situations that could be demeaning to the residents. The policy lacked direction for the use of incontinence products, including incontinence pads.</p> <p>SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review/revise policies on dignity and educate all staff on those policies. The DON and/or designee could conduct audits of resident cares to ensure incontinent pads are not left where others can see them..</p> <p>TIME PERIOD FOR CORRECTION: Twenty one (21) days.</p>	21805		
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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 12, 2023

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

RE: CCN: 245564
Cycle Start Date: March 29, 2023

Dear Administrator:

On May 11, 2023, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Please contact me with any questions regarding this letter.

Sincerely,

A handwritten signature in black ink that reads 'Lori Hagen'.

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 12, 2023

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

Re: Reinspection Results
Event ID: ZKPZ12

Dear Administrator:

On May 11, 2023, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 29, 2023. At this time these correction orders were found corrected.

Please contact me with any questions regarding this letter.

Sincerely,

A handwritten signature in black ink that reads 'Lori Hagen'.

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us