Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 2, 2022

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

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

Dear Administrator:

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

As authorized by CMS the remedy of:

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

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 Therefore, the NATCEP prohibition is rescinded.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

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

Electronically delivered

December 2, 2022

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

Re: Reinspection Results
Event ID: P0CY12

Dear Administrator:

On November 16, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 28, 2022 . At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

Electronically delivered
October 12, 2022

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

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

Dear Administrator:

On September 28, 2022, 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.

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:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by December 28, 2022 (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 March 28, 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 dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

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

Electronically delivered
October 12, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: P0CY11

Dear Administrator:

The above facility was surveyed on September 27, 2022 through September 28, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245564	A. BUILDING _____ B. WING _____	C 09/28/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 9/27/22, to 9/28/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED. H55644789C (MN00087041) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and	F 688		11/1/22

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

Electronically Signed | 10/19/2022

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

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F 688	Continued From page 1 services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide range of motion (ROM) treatment/services and assistance to improve and maintain mobility as recommended by therapy for 1 of 2 residents (R1) reviewed for mobility. Findings include: R1's quarterly Minimum Data Set (MDS) dated 8/24/22, identified R1 had moderate cognition impairment and diagnoses which included anemia (low blood count), hypertension (high blood pressure), diabetes mellitus, dementia, and depression. The MDS also indicated R1 required extensive assist of 1 staff for bed mobility, transfers, ambulation, dressing, personal hygiene, and toilet use. R1 had no impairments in functional range of motion for upper or lower extremities. The MDS further indicted R1 had not received physical therapy (PT), occupational therapy (OT) or restorative nursing programs. R1's current face sheet identified diagnoses generalized muscle weakness, macular degeneration, and fibromyalgia. R1's current care plan dated 7/30/22, identified R1 was at risk for decline in mobility (r/t) related	F 688	R1's Functional Maintenance Program (FMP) was reviewed/revised. A therapy screen was done for R1 for ambulation and possible decline. R1 was picked up by therapy. All residents who are on a FMP or a Restorative program could be affected. All residents with a FMP were reviewed for completion/documentation of their program. Therapy screens were done on residents with possible decline in ambulation. Ambulation and ROM programs are scheduled in the EHR and the paper schedule was also updated with instructions on how to document refusals and completions. An exercise group for ROM was started and is led by a restorative aid. Weekly Restorative meetings will be started to ensure that programs are being completed/reviewed and updated as needed. DON or designee started education on 9/30/22 to all nursing staff on documentation, updates to the schedule and resident programs. Along with the importance on communicating refusals and changes with the residents to the	

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F 688	Continued From page 2 to diagnoses muscle weakness, osteoarthritis, and fibromyalgia. The care plan indicated R1 was to receive a functional maintenance program (FMP) a minimum of 3 times a week and up to 5 times a week. Additionally, R1 had decreased mobility r/t fracture of right hip on 3/21/22. The care plan directed staff to ambulate R1 with assist of 1 to 2 with walker 3 times a day, every day. R1's Fall Risk Assessment dated 8/25/22, identified unsteady gait and only able to stabilize with human assistance, weak, and high risk for falls. R1's physical therapy discharge summary dated 5/20/22, identified following R1's hip fracture and surgical repair significant progress had been made from full assist for mobility and using lift to independent with bed mobility, walking with FWW 20 to 40 feet. Staff educated on FMP and walking with R1. Discharge recommendations: continue walking with FMP and strength exercises. R1 was to receive a program of ambulation and lower extremity (LE) exercises 3 to 5 times weekly, dated 5/4/22. The program included: -Ambulation with front wheeled walker (FWW) assist of 1 with wheelchair follow and gait belt 15 to 30 feet two times, slow gait. -Nustep (lower extremity machine) level two 5 to 10 minutes, slow movements. -Walk to and from chair with FWW five times and if she cannot walk perform pivots. R1's FMP assessments completed by Therapy Manager (TM) identified the following: -On 4/1/22, resident had recent fall with major injury and was working with active therapies. FMP will be placed on hold until active therapies has	F 688	nursing staff. All staff was educated on the findings on the MDH visit. DON or designee will perform audits 3x/week for 4 weeks, 2x/week for 4 weeks, then weekly thereafter to see that documentation and programs are being done as directed. Findings with be brought to QAPI for further recommendations.	

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F 688	Continued From page 3 been discontinued. -On 5/28/22, FMP 3 to 5 times a week. Resident recently discharged from active therapies. Changes made to FMP. -On 8/24/22, frequency of program: active range of motion 3 to 5 times a week. Goal: Resident will participate with Functional Maintenance (FMP) a minimum of 3 times a week. Evaluation: Staff continue to encourage resident participation in in FMP. Resident frequently declines. Staff may bring equipment to room if needed. No changes. The FMP assessments lacked any documentation related R1's ambulation status including her ability to complete the ordered therapy/exercises. R1's FMP daily flow sheets completed when specified therapy/exercises were completed and documented identified the following: -May 2022, on 5/11/22, and 5/31/22, 15 minutes of therapy/exercises. R1 refused on 5/30/22 (only receiving the FMP twice the entire month of May). -June 2022, on 6/7/22, 6/9/22, and 6/14/22, 20 minutes of therapy/exercises and 6/15/22, 15 minutes of therapy/exercises (only receiving the FMP 4 days). -July 2022, on 7/5/22, refused, 7/10/22, 15 minutes of therapy/exercises, and 7/20/22, out of building (only receiving the FMP 1 day). -August 2022, on 8/18/22, 8/21/22, 15 minutes of therapy/exercises, 8/20/22, and 8/22/22, 16 minutes of therapy/exercises, and 8/24/22, 20 minutes of therapy/exercises (only receiving the FMP 5 days). -Sept 2022, on 9/4/22, 16 minutes of therapy/exercises, 9/6/22, 9/20/22, and 9/27/22, 15 minutes of therapy/exercises (only receiving	F 688		

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F 688	Continued From page 4 the FMP 4 days). There was no further information documented on the sheets. Review of R1's nursing assistant (NA) activities of daily living (ADL) flow sheets for the months of May, June, July, August, September 2022, identified the following additional ambulation: -May, on 5/29/22 and 5/31/22 walked in room (2 days) -June, on 6/3/22, 6/11/22, 6/13/22, 6/16/22, 6/18/22, 6/19/22, 6/20/22, 6/21/22, 6/22/22, 6/24/22, 6/25/22, 6/27/22, 6/30/22, walked in room (13 days) -July, on 7/4/22, 7/6/22, 7/8/22, 7/9/22, 7/10/22, 7/16/22, 7/25/22, 7/26/22, 7/28/22, walked in room (9 days) -August, on 8/10/22, 8/16/22, 8/23/22, and 8/24/22 (4 days) -September, on 9/13/22, walked in corridor (1 day) The ADL flow sheets lacked documentation of R1's ambulation duration status including her ability to complete the ordered therapy/exercises. Review of R1's progress notes dated 8/24/22, at 11:00 a.m. care conference identified PT/OT completed see therapy detail for plan of care (POC) goals. R1's progress notes lacked any documentation related to R1's ambulation status including her ability to complete the ordered therapy/exercises. On 9/27/22 at 12:00 p.m. nursing assistant (NA)-C pushed R1 out of her room in wheelchair down to the dining room. -At 1:12 p.m. NA-C pushed R1 in wheelchair from the dining room back to her room. NA-C removed	F 688		

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F 688	Continued From page 5 oxygen tubing from her face, applied gait belt, assisted R1 to standing, pivoted, and lowered her down onto the bed. R1 laid on her left side. NA-C replaced the oxygen tubing to her face, lowered the bed, covered her up, and shut off the lights. -At 1:30 p.m. 2:00 p.m., 2:30 p.m., 3:00 p.m., 4:00 p.m., and 4:30 p.m. R1 laid in her low bed on left side, covered up with blankets, fall mat and sensor on floor next to the bed. No staff were observed to offer or encourage R1 to ambulate to in the room, hallway, or to and from the dining room. During an observation/interview on 9/28/22, at 1:44 p.m. NA-E pushed R1 in wheelchair into her room from the dining room. NA-E entered the bathroom while R1 remained in the wheelchair. NA-E applied a gait belt and gave R1 cues while she grabbed the bar on the wall and stood up. NA-E instructed R1 to pivot onto toilet. R1 sat down onto toilet with difficulty. NA-E held onto gait belt, gave R1 cues to stand up, and pivoted into wheelchair. R1 washed her hands at the sink and NA-E pushed her over to the bed. R1 took a hold of the short bed railing and slowly pulled herself up to standing, pivoted and lower herself onto the bed. NA-E replaced oxygen nasal cannula on R1's face, lifted her legs/feet onto the bed, placed a pillow under her knees, lowed bed, adjusted fall and sensor mats, and exited room. NA-E stated it had been quite a while since she had walked R1. NA-E indicated R1 had been on a walking and exercise program and thought therapy staff completed that. During an interview on 9/27/22, at 1:30 p.m. nursing assistant (NA)-A stated R1 transfers	F 688		

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F 688	Continued From page 6 stand by assist of 1 and pivots, she really did not walk. NA-A indicated after R1 fell and broke her hip she received therapy and when discharged from there she went to the FMP program and worked on exercises and walking. NA-A identified R1 only goes to FMP when she felt up to it and was unsure of how often. During an interview on 9/27/22, at 2:00 p.m. exercise therapy aide (ET)-A stated R1 had not done much therapy. ET-A also stated R1 should have completed at least 15 minutes of the program at least 3 times a week. ET-A indicated R1 could no longer complete the bike exercise and needed to be reassessed. ET-A stated R1's POC had not been updated since May 2022. ET-A identified R1 refused therapy a lot, had less strength, and her mobility was slower since she fell and fractured her hip March 2022. During an interview on 9/27/22, at 2:15 p.m. ET-B stated R1 had become weaker especially this past month. ET-B indicted R1 had been unable and no longer completed the bike exercise. ET-B also stated she had been aware therapy had not been completed as ordered and "sometimes it just did not get done due to a shortage of staff". During an interview on 9/27/22, at 3:20 p.m. NA-C stated R1 required assistance with all cares and a very high risk for falls. NA-C indicated R1's strength had gotten worse and had been able to walk to her meals all the way to the dining room about 250 feet before she fractured her hip. NA-C identified R1 had seemed withdrawn and had observed her complete therapy only a couple of times during the past two months. During an interview on 9/27/22, at 4:11 p.m.	F 688		

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	245564	A. BUILDING _____ B. WING _____	C 09/28/2022

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F 688	Continued From page 7 family member (FM) stated she had been worried R1 had gotten weaker and may fall again. FM indicated R1 did refuse some of the therapy at times and had not been walking or taken part in therapy recently. FM also stated R1 verbalized she wanted to be able to walk again and not fall. During an interview on 9/28/22, at 9:15 a.m. NA-D stated she had transferred R1 from her bed to the wheelchair to take her to the bathroom. NA-D indicated R1 usually did not walk and understood staff were expected to transfer with the wheelchair only. During an interview on 9/28/22, at 9:45 a.m. R1 stated she had refused therapy at times. R1 indicated she wanted to get stronger but needed more encouragement from staff. R1 stated she felt weaker and struggled to get out of bed. R1 also stated she needed therapy but did not like it. R1 indicated she had therapy until the end of May 2022, after it ended, she felt like she had been dropped from therapy. During an interview on 9/28/22, at 10:31 a.m. Director of Nursing (DON) stated staff were expected to have reported the FMP had not been done with R1 as ordered. DON also stated a new evaluation should be completed and a referral made to physical therapy agency. During an interview on 9/28/22, at 12:34 p.m. licensed practical nurse (LPN)-A stated staff were expected to walk R1 in the hallway only. LPN-A indicated she had been informed by the physical therapist staff R1 would have been encouraged to walk in her room by herself and that would not have been safe.	F 688		

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F 688	Continued From page 8 During an interview on 9/28/22, at 1:15 p.m. physical therapy assistant (PTA) stated R1 expected staff to continue with the FMP designed by the physical therapist 3 to 5 times a week. PTA stated R1 required upper and lower body strength to to safely transfer. PTA verified she had written in the staff communication book on 4/25/22, R1 can use FWW and assist of 1 to do stand pivot transfers from wheelchair to bed or recliner. PTA also stated R1 needed to continue with the ordered therapy program to maintain the strength she had in her hips, ROM, and to self propel herself in the wheelchair. PTA also stated the facility had not notified her of any changes needed. During an interview on 9/28/22, at 2:30 p.m. with trained medication assistant (TMA)-A stated she transferred R1 to and from the bathroom via wheelchair and unaware of the last time she saw R1 ambulating. TMA-A indicated R1 was mostly likely transported in the wheelchair to make it easier because of the oxygen tubing could have been an issue. TMA-A also stated, "I have not encouraged her to walk but planned on starting today". During an interview on 9/28/22, at 3:00 p.m. NA-B stated R1 needed assistance with transfers. NA-B also stated she had not walked R1, lacked information, and had not seen her walk since she started work there over 8 months ago. NA-B indicated R1 had some falls and R1 told her she really wanted to walk but needed help to get stronger. During an interview on 9/28/22, at 3:15 p.m. registered nurse (RN) stated the NA ADL flow sheets provided additional information however	F 688		

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F 688	Continued From page 9 lacked documentation of the distance the resident walked. The FMP should be evaluated by a nurse periodically to ensure it is being followed and there was no decline in ability. If refusals or decline, the resident should be referred back to therapy. During an interview on 9/28/22, at 3:40 p.m. therapy manager (TM) stated staff are expected to educate R1 on the how beneficial the therapy would have been, and it was her right to refuse. TM also stated staff are expected to have provided encouragement rather than taking away her therapy and do nothing. TM indicted R1 had never been a high participant in therapy and expected staff to communicate to her when a resident's plan needed to be changed and if they continued to refuse. TM indicated R1's therapy program should have met her needs, provided a program she would have liked and participated in, and helped keep and maintain her current level of function and ability to participate in her ADLS. During a telephone interview on 9/29/22, at 9:05 a.m. physical therapist (PT) stated R1 had been discharged from physical May 2022. PT also stated recommendations had been given to facility to continue ambulation and exercises 3 to 5 times a week and at least a minimum of 3 times a week. PT indicated the therapy/exercise program was intended for R1 to have maintained function as best as she could, keep her independent as possible and strong to lessen the chance of falling. PT stated she expected the facility to contact her or her assistant if R1 refused to take part in the therapy/exercise. Facility policy titled Restorative Nursing Program Classifications undated, identified the Functional	F 688		

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F 688	Continued From page 10 Maintenance Program was a therapy/exercise to be offered by the restorative nursing staff. The ambulation and range of motion (ROM) programs were provided to show maintenance of skill with or without adaptive devices. The daily flow sheet was to be completed when ambulation and/or ROM was completed.	F 688		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 9/27/22, to 9/28/22 a standard abbreviated survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. The following complaint was found to be	2 000		

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2 000	Continued From page 1 SUBSTANTIATED: H55644789C (MN00087041) 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. The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility	2 000		

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2 000	Continued From page 2 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide range of motion (ROM) treatment/services and assistance to improve and maintain mobility as recommended by therapy for 1 of 2 residents (R1) reviewed for mobility. Findings include:	2 895	Corrected	11/1/22

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2 895	Continued From page 3 R1's quarterly Minimum Data Set (MDS) dated 8/24/22, identified R1 had moderate cognition impairment and diagnoses which included anemia (low blood count), hypertension (high blood pressure), diabetes mellitus, dementia, and depression. The MDS also indicated R1 required extensive assist of 1 staff for bed mobility, transfers, ambulation, dressing, personal hygiene, and toilet use. R1 had no impairments in functional range of motion for upper or lower extremities. The MDS further indicted R1 had not received physical therapy (PT), occupational therapy (OT) or restorative nursing programs. R1's current face sheet identified diagnoses generalized muscle weakness, macular degeneration, and fibromyalgia. R1's current care plan dated 7/30/22, identified R1 was at risk for decline in mobility (r/t) related to diagnoses muscle weakness, osteoarthritis, and fibromyalgia. The care plan indicated R1 was to receive a functional maintenance program (FMP) a minimum of 3 times a week and up to 5 times a week. Additionally, R1 had decreased mobility r/t fracture of right hip on 3/21/22. The care plan directed staff to ambulate R1 with assist of 1 to 2 with walker 3 times a day, every day. R1's Fall Risk Assessment dated 8/25/22, identified unsteady gait and only able to stabilize with human assistance, weak, and high risk for falls. R1's physical therapy discharge summary dated 5/20/22, identified following R1's hip fracture and surgical repair significant progress had been made from full assist for mobility and using lift to independent with bed mobility, walking with FWW 20 to 40 feet. Staff educated on FMP and walking	2 895		

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2 895	Continued From page 4 with R1. Discharge recommendations: continue walking with FMP and strength exercises. R1 was to receive a program of ambulation and lower extremity (LE) exercises 3 to 5 times weekly, dated 5/4/22. The program included: -Ambulation with front wheeled walker (FWW) assist of 1 with wheelchair follow and gait belt 15 to 30 feet two times, slow gait. -Nustep (lower extremity machine) level two 5 to 10 minutes, slow movements. -Walk to and from chair with FWW five times and if she cannot walk perform pivots. R1's FMP assessments completed by Therapy Manager (TM) identified the following: -On 4/1/22, resident had recent fall with major injury and was working with active therapies. FMP will be placed on hold until active therapies has been discontinued. -On 5/28/22, FMP 3 to 5 times a week. Resident recently discharged from active therapies. Changes made to FMP. -On 8/24/22, frequency of program: active range of motion 3 to 5 times a week. Goal: Resident will participate with Functional Maintenance (FMP) a minimum of 3 times a week. Evaluation: Staff continue to encourage resident participation in in FMP. Resident frequently declines. Staff may bring equipment to room if needed. No changes. The FMP assessments lacked any documentation related R1's ambulation status including her ability to complete the ordered therapy/exercises. R1's FMP daily flow sheets completed when specified therapy/exercises were completed and documented identified the following:	2 895		

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2 895	Continued From page 5 -May 2022, on 5/11/22, and 5/31/22, 15 minutes of therapy/exercises. R1 refused on 5/30/22 (only receiving the FMP twice the entire month of May). -June 2022, on 6/7/22, 6/9/22, and 6/14/22, 20 minutes of therapy/exercises and 6/15/22, 15 minutes of therapy/exercises (only receiving the FMP 4 days). -July 2022, on 7/5/22, refused, 7/10/22, 15 minutes of therapy/exercises, and 7/20/22, out of building (only receiving the FMP 1 day). -August 2022, on 8/18/22, 8/21/22, 15 minutes of therapy/exercises, 8/20/22, and 8/22/22, 16 minutes of therapy/exercises, and 8/24/22, 20 minutes of therapy/exercises (only receiving the FMP 5 days). -Sept 2022, on 9/4/22, 16 minutes of therapy/exercises, 9/6/22, 9/20/22, and 9/27/22, 15 minutes of therapy/exercises (only receiving the FMP 4 days). There was no further information documented on the sheets. Review of R1's nursing assistant (NA) activities of daily living (ADL) flow sheets for the months of May, June, July, August, September 2022, identified the following additional ambulation: -May, on 5/29/22 and 5/31/22 walked in room (2 days) -June, on 6/3/22, 6/11/22, 6/13/22, 6/16/22, 6/18/22, 6/19/22, 6/20/22, 6/21/22, 6/22/22, 6/24/22, 6/25/22, 6/27/22, 6/30/22, walked in room (13 days) -July, on 7/4/22, 7/6/22, 7/8/22, 7/9/22, 7/10/22, 7/16/22, 7/25/22, 7/26/22, 7/28/22, walked in room (9 days) -August, on 8/10/22, 8/16/22, 8/23/22, and 8/24/22 (4 days) -September, on 9/13/22, walked in corridor (1 day) The ADL flow sheets lacked documentation of	2 895		

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2 895	Continued From page 6 R1's ambulation duration status including her ability to complete the ordered therapy/exercises. Review of R1's progress notes dated 8/24/22, at 11:00 a.m. care conference identified PT/OT completed see therapy detail for plan of care (POC) goals. R1's progress notes lacked any documentation related to R1's ambulation status including her ability to complete the ordered therapy/exercises. On 9/27/22 at 12:00 p.m. nursing assistant (NA)-C pushed R1 out of her room in wheelchair down to the dining room. -At 1:12 p.m. NA-C pushed R1 in wheelchair from the dining room back to her room. NA-C removed oxygen tubing from her face, applied gait belt, assisted R1 to standing, pivoted, and lowered her down onto the bed. R1 laid on her left side. NA-C replaced the oxygen tubing to her face, lowered the bed, covered her up, and shut off the lights. -At 1:30 p.m. 2:00 p.m., 2:30 p.m., 3:00 p.m., 4:00 p.m., and 4:30 p.m. R1 laid in her low bed on left side, covered up with blankets, fall mat and sensor on floor next to the bed. No staff were observed to offer or encourage R1 to ambulate to in the room, hallway, or to and from the dining room. During an observation/interview on 9/28/22, at 1:44 p.m. NA-E pushed R1 in wheelchair into her room from the dining room. NA-E entered the bathroom while R1 remained in the wheelchair. NA-E applied a gait belt and gave R1 cues while she grabbed the bar on the wall and stood up. NA-E instructed R1 to pivot onto toilet. R1 sat down onto toilet with difficulty. NA-E held onto gait	2 895		

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2 895	Continued From page 7 belt, gave R1 cues to stand up, and pivoted into wheelchair. R1 washed her hands at the sink and NA-E pushed her over to the bed. R1 took a hold of the short bed railing and slowly pulled herself up to standing, pivoted and lower herself onto the bed. NA-E replaced oxygen nasal cannula on R1's face, lifted her legs/feet onto the bed, placed a pillow under her knees, lowed bed, adjusted fall and sensor mats, and exited room. NA-E stated it had been quite a while since she had walked R1. NA-E indicated R1 had been on a walking and exercise program and thought therapy staff completed that. During an interview on 9/27/22, at 1:30 p.m. nursing assistant (NA)-A stated R1 transfers stand by assist of 1 and pivots, she really did not walk. NA-A indicated after R1 fell and broke her hip she received therapy and when discharged from there she went to the FMP program and worked on exercises and walking. NA-A identified R1 only goes to FMP when she felt up to it and was unsure of how often. During an interview on 9/27/22, at 2:00 p.m. exercise therapy aide (ET)-A stated R1 had not done much therapy. ET-A also stated R1 should have completed at least 15 minutes of the program at least 3 times a week. ET-A indicated R1 could no longer complete the bike exercise and needed to be reassessed. ET-A stated R1's POC had not been updated since May 2022. ET-A identified R1 refused therapy a lot, had less strength, and her mobility was slower since she fell and fractured her hip March 2022. During an interview on 9/27/22, at 2:15 p.m. ET-B stated R1 had become weaker especially this past month. ET-B indicted R1 had been unable and no longer completed the bike exercise. ET-B	2 895		

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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
2 895	Continued From page 8 also stated she had been aware therapy had not been completed as ordered and "sometimes it just did not get done due to a shortage of staff". During an interview on 9/27/22, at 3:20 p.m. NA-C stated R1 required assistance with all cares and a very high risk for falls. NA-C indicated R1's strength had gotten worse and had been able to walk to her meals all the way to the dining room about 250 feet before she fractured her hip. NA-C identified R1 had seemed withdrawn and had observed her complete therapy only a couple of times during the past two months. During an interview on 9/27/22, at 4:11 p.m. family member (FM) stated she had been worried R1 had gotten weaker and may fall again. FM indicated R1 did refuse some of the therapy at times and had not been walking or taken part in therapy recently. FM also stated R1 verbalized she wanted to be able to walk again and not fall. During an interview on 9/28/22, at 9:15 a.m. NA-D stated she had transferred R1 from her bed to the wheelchair to take her to the bathroom. NA-D indicated R1 usually did not walk and understood staff were expected to transfer with the wheelchair only. During an interview on 9/28/22, at 9:45 a.m. R1 stated she had refused therapy at times. R1 indicated she wanted to get stronger but needed more encouragement from staff. R1 stated she felt weaker and struggled to get out of bed. R1 also stated she needed therapy but did not like it. R1 indicated she had therapy until the end of May 2022, after it ended, she felt like she had been dropped from therapy. During an interview on 9/28/22, at 10:31 a.m.	2 895		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00668	A. BUILDING: _____ B. WING _____	C 09/28/2022

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2 895	Continued From page 9 Director of Nursing (DON) stated staff were expected to have reported the FMP had not been done with R1 as ordered. DON also stated a new evaluation should be completed and a referral made to physical therapy agency. During an interview on 9/28/22, at 12:34 p.m. licensed practical nurse (LPN)-A stated staff were expected to walk R1 in the hallway only. LPN-A indicated she had been informed by the physical therapist staff R1 would have been encouraged to walk in her room by herself and that would not have been safe. During an interview on 9/28/22, at 1:15 p.m. physical therapy assistant (PTA) stated R1 expected staff to continue with the FMP designed by the physical therapist 3 to 5 times a week. PTA stated R1 required upper and lower body strength to to safely transfer. PTA verified she had written in the staff communication book on 4/25/22, R1 can use FWW and assist of 1 to do stand pivot transfers from wheelchair to bed or recliner. PTA also stated R1 needed to continue with the ordered therapy program to maintain the strength she had in her hips, ROM, and to self propel herself in the wheelchair. PTA also stated the facility had not notified her of any changes needed. During an interview on 9/28/22, at 2:30 p.m. with trained medication assistant (TMA)-A stated she transferred R1 to and from the bathroom via wheelchair and unaware of the last time she saw R1 ambulating. TMA-A indicated R1 was mostly likely transported in the wheelchair to make it easier because of the oxygen tubing could have been an issue. TMA-A also stated, "I have not encouraged her to walk but planned on starting today".	2 895		

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2 895	Continued From page 10 During an interview on 9/28/22, at 3:00 p.m. NA-B stated R1 needed assistance with transfers. NA-B also stated she had not walked R1, lacked information, and had not seen her walk since she started work there over 8 months ago. NA-B indicated R1 had some falls and R1 told her she really wanted to walk but needed help to get stronger. During an interview on 9/28/22, at 3:15 p.m. registered nurse (RN) stated the NA ADL flow sheets provided additional information however lacked documentation of the distance the resident walked. The FMP should be evaluated by a nurse periodically to ensure it is being followed and there was no decline in ability. If refusals or decline, the resident should be referred back to therapy. During an interview on 9/28/22, at 3:40 p.m. therapy manager (TM) stated staff are expected to educate R1 on the how beneficial the therapy would have been, and it was her right to refuse. TM also stated staff are expected to have provided encouragement rather than taking away her therapy and do nothing. TM indicted R1 had never been a high participant in therapy and expected staff to communicate to her when a resident's plan needed to be changed and if they continued to refuse. TM indicated R1's therapy program should have met her needs, provided a program she would have liked and participated in, and helped keep and maintain her current level of function and ability to participate in her ADLS. During a telephone interview on 9/29/22, at 9:05 a.m. physical therapist (PT) stated R1 had been discharged from physical May 2022. PT also stated recommendations had been given to	2 895		

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2 895	Continued From page 11 facility to continue ambulation and exercises 3 to 5 times a week and at least a minimum of 3 times a week. PT indicated the therapy/exercise program was intended for R1 to have maintained function as best as she could, keep her independent as possible and strong to lessen the chance of falling. PT stated she expected the facility to contact her or her assistant if R1 refused to take part in the therapy/exercise. Facility policy titled Restorative Nursing Program Classifications undated, identified the Functional Maintenance Program was a therapy/exercise to be offered by the restorative nursing staff. The ambulation and range of motion (ROM) programs were provided to show maintenance of skill with or without adaptive devices. The daily flow sheet was to be completed when ambulation and/or ROM was completed. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies related to restorative nursing/functional maintenance program, educate staff on the policies, and conduct an audit of all residents on the program to ensure it is being completed and documented as ordered. In addition, they could audit to ensure a licensed nurse evaluates the program and each resident on the program periodically to ensure appropriate. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		