STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chosen Valley Care Center	1102 Liberty Street Southeast Chatfield, MN 55923

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49893 Based on observation, interview, and record review, the facility failed to resume restorative services for 1 of 2 residents (R4) reviewed for limited range of motion . Findings include: R4's significant change Minimum Data Set (MDS) assessment, dated 6/15/24 indicated R4 as cognitively intact with no behaviors or rejection of cares, limited upper and lower range of motion to one side, and dependent on staff for activities of daily living (ADLs) R4's diagnoses list included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (limited to no movement following stroke), chronic pain, central pain syndrome (pain as the result in brain injury), muscle weakness, repeated falls, and neurologic neglect syndrome (a disorder that causes the body to favor one side over the other after injury to the brain). During an interview on 7/9/2024 at 8:52 a.m., R4 stated she has not participated in exercises or therapy for at least 2-3 weeks. R4 stated she would like to do exercises to increase her chances of going home. R4's care plan dated 3/1/24, indicated impaired mobility, dependent on staff for transferring, repositioning, and ADL's. A progress note dated 6/17/2024 indicated, her [R4] progress is not quite at the skilled level. Her progress seems more at the restorative level than the skilled level so please make therapy aware . During interview on 7/11/2024 at 10:13 a.m., rehab tech-C stated R4 is not currently receiving physical or occupational therapy (OT). She stated R4 was discharged from physical therapy on 5/20/24 and occupational therapy on 6/8/24 due to returning to her prior level of functioning. Restorative programs are set up by the therapy department with tasks performed by a therapy and facility restorative tech. Rehab tech-C stated there was no active restorative program for R4. During interview on 7/11/24 at 10:14 a.m., restorative tech-D stated R4 had been on a restorative program however, he was unsure why it ended. Indicating programs are kept and documented in a binder. He confirmed the binder lacked a program for R4. The restorative tech stated the therapy department monitors the restorative program in conjunction with the restorative nurse (CM-A) (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245423	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/12/2024

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Chosen Valley Care Center	1102 Liberty Street Southeast Chatfield, MN 55923

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 7/11/24 at 11:03 a.m., the therapy director stated R4 had an active restorative program until a recent hospitalization . She assumed the program would restart upon R4's return from the hospital. The therapy director confirmed the program should have been restarted however was not. A physical therapy evaluation discharge summary dated 5/20/2024 indicated Restorative range of motion program established: seated [NAME] [lower extremities] ROM exs [exercises]. A Therapy Communication to Nursing form dated 11/10/2023 indicated exercises as follows: 1. Stand in stand aide/white frame for 1-5 minutes as tolerated-will need to assist LUE (left upper extremity) to remain on bar to prevent leaning 2. AAROM (active assisted range of motion) of LUE-all joints 3. AROM (active range of motion) (AAROM if necessary to due to shoulder pain) of RUE (right upper extremity)-all joints. R4's restorative progress notes dated 12/15/23 indicated R4 was started on restorative program and listed specific exercise for R4 to perform. Restorative progress notes dated 3/29/24 indicated changes to R4's restorative program. Progress notes dated 5/10/24 indicated R4's restorative program was discontinued due to R4 working with skilled therapy and would be reevaluated upon completion of skilled therapy. During interview on 7/11/2024 at 11:45 a.m., CM-A stated restorative programs are established by therapy upon admission and discharge from therapy programs. Therapy gives restorative recommendations on a restorative therapy communication form. CM-A stated R4 had been on a restorative program however was put on hold due to starting skilled therapy 5/10/24. She stated therapy did not give any recommendations following end of skilled services and confirmed she did not follow up with therapy. CM-A stated she changed how she follows up with therapy to ensure restorative programs are restarted if appropriate. During interview on 7/11/2024 at 3:20 p.m., the director of nursing stated restorative programs are established by therapy and then monitored by CM-A. She stated she would have expected therapy and CM-A to follow up with restorative program. A restorative policy from MED-PASS revised July 2017 indicates: Residents will receive restorative nursing care as needed to help promote optimal safety and independence. policy interpretation and implementation. Restorative nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitative services. Residents may be started on a restorative program upon admission, during the course of stay or when discharged from rehabilitative care. Restorative goals and objectives are individualized and resident-centered, and are outlined in the resident's plan of care. Restorative goals may include, but are not limited to supporting and assisting the resident in: A. adjusting or adapting to changing abilities (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. developing, maintaining, or strengthening his/her physiological and psychological resources. C. maintaining his/her dignity, independence and self-esteem and participating in the development and implementation of his/her plan of care.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47638 Based on observation, interview, and document review, the facility failed to monitor orthostatic blood pressures during the use of an antipsychotic medication for 3 of 4 residents (R6, R28, and R56) reviewed for psychotropic medications. Findings include: R6's quarterly Minimum Data Set (MDS) assessment, dated 5/10/24, identified R6 as cognitively intact, required extensive assistance with all activities of daily living (ADL's), and received antipsychotic, antianxiety, and antidepressant medications. R6's diagnoses included cancer, anemia, hypertension, diabetes mellitus (DM), hyperlipidemia, dementia, anxiety, depression, psychotic disorder, and lung disease. R6's physician orders included order for Diazepam (anxiolytic and sedative) 7.5 milligram (mg) by mouth daily for anxiety; Levomilnacipran (antidepressant) 120mg daily for antidepressant; Quetiapine Fumarate (antipsychotic) 150mg daily for major depression with psychotic symptoms related to unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; and an order to monitor orthostatic blood pressure while on Seroquel (Quetiapine Fumarate) every 30 day(s). R6's medical record was reviewed and lacked any evidence orthostatic blood pressures had been obtained for R6 in the past six months. R28's significant change Minimum Data Set (MDS) dated [DATE], identified R28 had severe cognitive impairment, required assistance with all activities of daily living (ADL)'s, and received an antipsychotic medication. R28's diagnoses included non-traumatic brain dysfunction, hypertension, diabetes mellitus, Alzheimer's disease, and depression. R28's care plan dated 7/2/24, indicated potential for psychotropic drug adverse drug reaction (ADR's) related to daily use of psychotropic medications which may increase risk of falls and included to monitor for side effects by completing monthly orthostatic blood pressure checks. R28's physician orders included order for Lexapro (antidepressant) 20 milligram (mg) by mouth daily for Alzheimer's dementia with behavioral disturbance related to major depressive disorder; order for Haloperidol Lactate (antipsychotic) 0.3 milliliter (ml) by mouth one time a day for delirium and nausea/vomiting; and an order to monitor orthostatic blood pressures while on Haldol in the morning every 28 day(s). R28's medical record was reviewed and lacked any evidence orthostatic blood pressures had been obtained for R28 in the past six months. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R56's quarterly Minimum Data Set (MDS) dated [DATE], identified R56 had severe cognitive impairment and required assistance with all activities of daily living (ADL)'s. R56's diagnoses included non-traumatic brain dysfunction, heart failure, Alzheimer's disease with late onset and depression. R56's care plan dated 5/23/24, indicated potential for psychotropic drug adverse drug reaction (ADR's) related to daily use of psychotropic medications which may increase risk of falls and included to monitor for side effects by completing monthly orthostatic blood pressure checks. R56's physician orders included orders for Lorazepam (antianxiety) 2 mg/ml - 0.25 ml sublingually every 2 hours as needed for anxiety (restlessness, nausea, insomnia); order for Sertraline HCL (antidepressant) 25 mg mouth daily for depression and Haloperidol Lactate (antipsychotic) 0.5 ml by mouth every two hours as needed for agitation for 14 days. Signed physician's orders, dated 6/14/24, lacked orders to monitor orthostatic blood pressures while on Haloperidol. During interview on 7/11/24 at 1:36 p.m., registered nurse case manager (RN)-A stated orthostatic blood pressures should be done monthly on any resident who receive antipsychotic's. RN-A confirmed antipsychotic medications were given and the care plan included to complete orthostatic blood pressures to monitor for side effects from the prescribed medications and confirmed monitoring was not completed for several months. RN-A stated it was important to monitor orthostatic blood pressures as is an adverse side effect of antipsychotic medications. During interview on 7/11/24 at 4:00 p.m., director of nursing (DON) stated orthostatic blood pressures should be obtained for any resident on an antipsychotic medication except if the provider wrote an exclusion for orthostatic blood pressures not to be obtained. DON stated it was important for orthostatic blood pressures to be obtained for on-going monitoring of side effects (such as hypotension) from the antipsychotic medication. And confirmed they were not completed. During interview on 7/11/24 at 2:49 p.m., consultant pharmacist (CP) stated orthostatic blood pressures should be monitored for residents who received antipsychotic medications. CP stated it was important to obtain orthostatic blood pressures as antipsychotic medication can cause hypotension and could lead to increased falls. A facility Antipsychotic Medication Use policy, dated 7/2022, indicated nursing staff shall monitor for and report any of the following side effects and adverse consequents of antipsychotic mediations to the attending physician: orthostatic hypotension.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47638 Based on interview and document review, the facility failed to arrange dental services after a non-urgent/routine dental referral was placed for 1 of 1 residents (R36) reviewed for dental concerns. Findings include: R36's quarterly Minimum Data Set (MDS) assessment, dated [DATE], identified moderately impaired cognition with medical diagnoses of diabetes mellitus (DM), hyperlipidemia, seizure disorder or epilepsy, depression, and medically complex conditions. R36 required extensive assistance for most activities of daily living (ADL's) and R36 was usually understood. R36 was identified as having a life expectancy of greater than six months. R36's care plan, edited [DATE], identified R36 wears upper and lower dentures and needs help to cleanse them. R36 was seen during an in house contracted dental services for his annual exam on [DATE], and there was no need for a dental referral at this time. R36 will be seen yearly and as needed. Interventions included oral and denture care and placement daily as well as arrangement of a dental consultation when needed. R36's oral health screening form, dated [DATE], identified R36 had full upper denture and no lower denture. Oral/dental status identified inflamed or bleeding gums or loose natural teeth. Recommendations indicated a routine dental referral to address residents non-urgent dental care needs. It is also noted to nursing staff for follow up/care conference that R36 is interested in having spaces filled/new lower denture. R36's dental assessment progress note, dated [DATE] noted the dental referral was made and awaiting response from responsible party to proceed. R36's care conference note, dated [DATE] indicated resident, his wife (responsible party), and his daughter (emergency contact) were in attendance along with facility staff. R36's diet was noted as regular texture and consistency with no concentrated sweets and no added salt. It was noted that care plan was reviewed. There was no mention of dental screening or referral. Master Patient list dated [DATE] includes R36's name and date of birth. This list is to be returned to Community Care Coordinator (CCC)-H with any discharges or deceased status updates. The facility policy, titled Dental Services indicates a social services representative will assist residents with appointments, transportation arrangements, and all dental services provided are recorded in the resident's medical record. During interview on [DATE] at 11:18 a.m., R36 stated he would like to have his teeth checked. He denied any current pain. He could not recall when he last saw a dentist and did not believe he has seen a dentist since his admission to the facility [DATE]. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on [DATE] at 11:52 a.m., resident representative (RR)-I stated R36 had not talked about seeing a dentist and she had not heard anything from the facility staff about a dental referral. RR-I stated she would consider new lower dentures to ease his mind and thinks this may be a good idea. During interview on [DATE] at 9:06 a.m., CCC-H stated R36 has not been seen as a patient by the dentist. R36 has been seen in the facility by a hygienist for an oral health screening. CCC-H would speculate R36 wishes to be seen as a patient. CCC-H stated when the box is checked on the screening form, indicating a routine referral is recommended, the facility then needs to complete additional paperwork includes resident medical history, insurance, and privacy information and sends this to her. After CCC-H receives this paperwork, she then calls the resident, guardian, or responsible party to schedule the exam and cleaning and determine any additional treatment needed. CCC-H stated there are times in which the hygienist will mark the referral box and the resident may not be ready to take the next step in which the resident would need to let the facility know they would like to proceed with scheduling. During interview on [DATE] at 11:03 a.m., Licensed Practical Nurse (LPN)-A stated after a dental visit, the screening form is given to the nurse. The nurse puts a note in the resident's electronic health record (EHR) and places the form in the resident's hard chart. If a referral is needed LPN-A would make a copy of the form and give the copy to the case manager and they take it from there. During interview on [DATE] at 11:12 a.m., case manager (CM)-B stated after a dental screening the form is charted and then brought to the case manager. If the resident is a current patient with the dentist, the dentist will put them on the list to be seen. If the resident is not a current patient, they (facility staff) will reach out to the number one contact and get paperwork completed and sent to dentist. If it is an urgent issue, they would let the family know that they need to be seen and they will assist with arrangements for an appointment. CM-B stated a routine referral is generally checked for a cleaning and is considered non-urgent, and they do not get worried about routine referrals. CM-B was not aware of the policy regarding dental cleanings and believes it may be required every 6 months and depends on when they last had a cleaning. CM-B did not believe the screenings counted as a cleaning and were more of an oral evaluation to determine if there are additional needs. During interview on [DATE] at 11:23 a.m., with Director of Social Services (DSS) stated all residents are seen by hygienist annually for MDS regardless of active concerns or not. dentist then reaches out to the responsible party if there is a referral or any type of need for follow up. DSS stated R36 is on the list of an active patients of theirs so the dentist would handle all steps after the visit. DSS stated after the documentation is put in the resident's EHR the paperwork is placed in a subfile after she has given a copy to the case managers. DSS stated they (facility staff) do not handle any of the scheduling or follow up if the resident is an active/current patient of dentist. DSS stated the lack of progress with this referral is on the dentist end. The dentist are in the facility monthly and would prioritize the residents' needing visits based on urgency and they usually see ,d+[DATE] residents each visit/month and includes independent living (IL) and assisted living (AL) residents as well. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on [DATE] at 12:15 p.m., Director of Nursing (DON) stated she believed if the dentist made a referral they also made the arrangements for the follow up appointment or services needed. DON stated they should be following up to ensure the recommendations are being followed if the resident or their representative agrees with the plan of care. DON stated this is important to ensure continuity of care and they will be looking into this further to see what changes are needed for their current process. During interview on [DATE] at 12:33 p.m., DSS stated she contacted CCC-H and they determined the list of active dental patients was incorrect, and dentist does not have R36 listed as an active patient. DSS believed the resident was an active patient because he is on the list they receive from the dentist to confirm as current residents. DSS stated CCC-H informed her this was an error on their end. DSS stated will be going through the list to ensure no additional errors are present.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49893 Based on observation, interview, and record review, the facility failed to implement enhanced barrier precautions (EBP) for 1 of 1 (R53) resident reviewed for infection prevention related to presence of peripherally inserted central catheter (PICC) line (a tube inserted in the arm that ends in a blood vessel in the chest). Findings include: R53's admission Minimum Data Set (MDS) assessment dated [DATE] indicated R53 was cognitively intact. It further indicated presence of a central IV (intravenous) access and antibiotics. R53's diagnoses list included infection to internal right knee prosthesis (artificial joint), sepsis (infection in blood stream) methicillin susceptible staphylococcus aureus infection (type of bacteria), adjustment and management of vascular access device. R53's orders dated 6/21/24 included PICC line dressing change every 7 days, cefazolin sodium (antibiotic) use 3 grams intravenously three times a day for blood [stream] infection until 7/18/24, sodium chloride intravenous solution 0.9%. Use 10 ml intravenously three times a day for blood stream infection until 7/18/24. Flush 5 before and after medication. A hospital discharge summary dated 6/18/24 indicated follow-up with ortho ID (infectious disease) near the completion of the six-week course of cefazolin therapy on July 18th 2024. Central catheter management at the end of treatment: can be removed at the end of IV antimicrobials. During observation on 7/9/2024 at 9:39 a.m., a PICC line was noted in R53's right upper arm. R53's room lacked any indication of enhanced barrier precautions or personal protective equipment (PPE). During observation on 7/10/24 at 10:27 a.m., a nurse was observed performing hand hygiene and putting on gloves prior to entering R53's room. R53's room did not have additional PPE or signage indicating EBP was required for R53 prior to performing cares. Intravenous antibiotic was administered without the use of enhanced barrier PPE. During interview on 7/11/2024 at 11:45 a.m., the infection preventionist (CM-A) stated residents are screened at the time of admission and readmission for the initiation of enhanced barrier precautions. CM-A stated residents who have indwelling medical devices, chronic hard to heal wounds, catheters, and multidrug resistant organizations are required to be on precautions. After reviewing guidance from Centers for Medicare and Medicaid, CM-A confirmed R53 should have been placed on enhanced barrier precautions due to having a PICC line. CM-A stated EBP are necessary to protect residents at higher risk of infections from contracting or spreading infection to others. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/11/24 at 3:21 p.m., the director of nursing stated facility staff discussed EBP for PICC lines at length upon R53's admission to the facility and should have erred on the side of caution until they could clarify the regulation. An Enhanced Barrier Precautions policy dated August 2022 indicates enhanced barrier precautions are indicated when contact precautions do not otherwise apply for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. A handwritten addendum on the policy indicates No including PICC and chronic complex both dated 4/12/24 with CM-As initials.