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	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Browns Valley Health Center	114 Jefferson Street South Browns Valley, MN 56219

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844 Based on observation, interview and document review, the facility failed to ensure professional standards of practice were followed during medication set-up and administration of insulin with a Humalog insulin pen (rapid-acting insulin, used to improve blood sugar control in people with diabetes mellitus) for 1 of 1 residents (R11) who received insulin without the pen primed according to manufacturer's recommendations. Findings include: R11's significant change Minimum Data Set (MDS) dated [DATE], identified R11 had severe cognitive impairment and diagnoses which included arthritis, dementia, and diabetes mellitus (DM) and received injections of insulin. R11's care plan dated 10/7/24, identified R11 had DM and staff were to administer diabetic medications as ordered. R11's Order Summary Report signed 2/28/25, identified Humalog Kwik Pen 100 units per milliliter (ml) subcutaneous (an injection into the fatty tissue) per sliding scale (a scale that identifies how much insulin to administer per blood glucose readings) three times daily. Review of R11's treatment administration record (TAR) from 3/1/25 to 3/10/25, identified R11's blood glucose ranged from 177 to 347. Identified R11 received 2 to 8 units of Humalog insulin during this time period. During an observation on 3/10/25 at 4:38 p.m., registered nurse (RN)-A prepared R11's Humalog insulin RN-A removed the Humalog insulin pen from the medication cart, removed the tip, attached a needle to the end of the pen, dialed up 8 units of insulin picked up an alcohol wipe, went to R11's room and administered the 8 units of insulin to R11. RN-A then removed the needle from the end of the pen, placed it in the sharps container and sanitized her hands. RN-A did not prime the pen (waste 2 units of insulin to remove the air bubbles) per manufacturer's instructions prior to drawing up the 8 units of insulin. During an interview on 3/109/25 at 4:44 p.m., RN-A verified she had not primed the insulin pen prior to dialing up the 8 units of Humalog for R11 per manufacturer's recommendations. RN-A stated she did not need to prime the pen because she had administered R11's insulin earlier in the day. (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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/11/25 at 9:30 a.m., consultant pharmacist (CP) stated it was important to always prime an insulin pen prior to drawing up the dosage to ensure the residents received the correct dosage of insulin. During an interview on 3/11/25 at 1:35 p.m., director of nursing (DON) stated her expectation was that the insulin pen would have been primed prior to dialing up the insulin dose for R12 to ensure the proper dose of insulin was administered. Review of Humalog insulin manufactures package insert dated 7/23, identified the need to prime the pen before drawing up the insulin. Identified priming the pen means removing the air from the needle and cartridge. Identified if you do not prime the pen before each injection, you may get too much or too little insulin. Review of a facility policy titled Medication Administration revised 8/7/23, identified the facility would ensure all medications were administered safely according to current standards of practice and regulatory requirements.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45844 Based on observation, interview, and document review, the facility failed to ensure staff wore hair restraints in the kitchen. Further, the facility failed to ensure food and beverages stored in the refrigerators, were labeled, dated and discarded properly. This deficient practice had the potential to affect all 28 residents who received food and beverages from the refrigerators and the kitchen. Findings include: Hair nets: On 3/10/25 at 12:02 p.m., dietary manager (DM) was standing at the dishwasher pulling clean dishes out of the dishwasher. DM hair was approximately 1/4 inch in length and was not wearing any type of a hair restraint. On 3/10/25 at 12:05 p.m., during the kitchen tour with the (DM), the following concerns were identified: Kitchen refrigerator: -Several slices of ham on a plate wrapped in saran wrap with a date of 2/28/25. Freezer -10 hamburger patty's in a bag without notation of an open date. Resident refrigerator and freezer on the unit: Fridge: -one slice of apple pie covered with saran wrap on a plate without notation of a date. -3/4 jar of salsa with a black crusty substance around the lid without notation of an open date. -1/4 container of mayonnaise without notation of an open date and an expiration date of 6/27/24. -1/2 jar of Queso cheese without notation of an open date. -3/4 bottle of Italian dressing without notation of an open date. -one ham sandwich on a plate covered with saran wrap without notation of a date. -one bowl of chili without notation of a date. -1/4 container of peppermint mocha creamer without notation of a date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Freezer: -half bag of pizza rolls without notation of an open date. -half bag of French fries without notation of an open date. -half bag of chicken nuggets without notation of an open date. During an interview on 3/10/25 at 12:35 p.m., DM verified the above findings during the kitchen tour. DM stated his expectation was that all opened food should have been dated and thrown away after the shelf life or the expiration date. DM stated since his hair was not very long he was not aware he needed to wear a hair restraint in the kitchen. During an interview on 3/11/25 at 9:23 a.m., dietician stated her expectation was that all food items would have been dated once opened and thrown away after the shelf life or the expiration date to prevent a food borne-illness. Dietician further stated her expectation was that all all staff would have worn a hair restraint while in the kitchen. A facility policy titled Perishable Food Management reviewed 8/29/22, identified perishable foods were those likely to spoil, decay or become unsafe to consume if not refrigerated. Further, identified all food once opened should have been labeled, and dated when opened and include a use-by date or discard date. A facility policy titled Hair covering and restraints dated 1/31/2012, identified dietary staff must wear hair restraints (hairnet or bonnet) to prevent hair from contacting exposed food or clean dishes. Identified all of the hair needs to be covered.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844 Based on observation and interview, the facility failed to disinfect a multi-use glucometer(a machine that is used for blood glucose monitoring) after use for 2 of 2 residents (R11, R6) reviewed for blood glucose monitoring. This deficient practice had the ability to affect all 9 residents who required blood glucose monitoring. Findings include: The Centers for disease Control and Prevention (CDC) Infection Prevention for Blood Glucose Monitoring and Insulin Administration dated 2/6/2013, identified due to the risk of transmitting infectious diseases during assisted blood glucose (blood sugar) monitoring whenever possible, blood glucose meters should not be shared. If they must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions. R11 R11's significant change Minimum Data Set (MDS) dated [DATE], identified R11 had severe cognitive impairment and diagnoses which included, arthritis, dementia, and diabetes mellitus DM). Identified R11 required staff assistance with activities of daily living (ADL's). R11's current physicians orders signed 2/25/25, identified R11 required blood glucose monitoring checks three times daily. During an observation on 3/10/25 at 4:38 pm., registered nurse (RN)-A sanitized hands, applied gloves and removed a glucometer, strip and a lancet (small device with a needle used to get blood for blood glucose monitoring) from the top drawer of the medication cart. RN-A used the lancet to poke R11's finger and obtained a small drop of blood onto the glucometer strip. RN-A removed gloves and placed glucometer back into the medication cart without disinfecting the glucometer. RN-A proceeded to sanitize her hands and documented R11's blood glucose result on the computer. During an interview on 3/10/25 at 4:45 p.m., RN-A verified the glucometer was used for multiple residents. RN-A stated she should have disinfected the glucometer per manufacturer's guidelines prior to placing it into the drawer of the medication cart to prevent the spread of blood-borne infections. R6 R6's significant change MDS dated [DATE], identified R6 had moderate cognitive impairment and diagnoses which included dementia, renal insufficiency and DM. Identified R6 required staff assistance with ADL's. R6's current physicians orders signed 2/25/25, identified R6 required blood glucose monitoring checks three time daily on Monday, Wednesday, and Friday and as needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 3/10/25 at 6:47 p.m., licensed practical nurse (LPN)-A had done a blood glucose check using a glucometer on R6 in the common area on the unit. LPN-A walked to the cart and placed the glucometer in the top drawer. LPN-A was not seen disinfecting the glucometer. During an interview on 3/10/25 at 6:50 p.m., LPN-A verified the glucometer was used for multiple residents. LPN-A stated she had wiped the front of the glucometer with an alcohol wipe after doing R6's blood glucose monitoring. LPN-A stated she thought it was ok to use an alcohol wipe to disinfect the glucometer between residents. LPN-A stated she was unsure what the manufacturer's suggested to use to disinfect the glucometers between resident use. During a joint interview on 3/11/25 at 1:25 p.m., infections preventionist (IP) and director of nursing (DON) verified the glucometer in the top drawer of the medication cart was used for several residents and DON stated using an alcohol wipe was not appropriate to disinfect the glucometer between resident use. IP and DON stated their expectation was that the glucometer would have been disinfected between residents using a Sani-wipe or per manufacturer's guidelines to prevent blood- borne infections. Review of Manufacturers guideline for Assure Platinum glucometer undated, identified disinfecting the glucometer was to be completed using a commercially available EPA-registered disinfectant detergent or germicide wipe, or one milliliter (ML) of household bleach to 9 (ML) of water to achieve a 1:10 dilution, or bleach wipes. Review of a facility policy titled Cleaning/ Disinfecting Resident Care Equipment reviewed 1/25/22, identified reusable resident equipment including glucometer was to be decontaminated between residents following manufactures instructions.