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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 1D1E

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00286

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245566**
2.STATE VENDOR OR MEDICAID NO.
(L2) **844240100**

3. NAME AND ADDRESS OF FACILITY
(L3) **VALLEY VIEW HEALTHCARE & REHAB**
(L4) **510 EAST CEDAR STREET**
(L5) **HOUSTON, MN** (L6) **55943**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/03/2018** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **45** (L18)
13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel __ 6. Scope of Services Limit
__ 3. 24 Hour RN __ 7. Medical Director
__ 4. 7-Day RN (Rural SNF) __ 8. Patient Room Size
__ 5. Life Safety Code __ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Nicole Osterloh, HFE NE II 10/18/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Sr. Health Program Rep 10/18/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
07/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
CMS Certification Number (CCN): 245566

October 16, 2018

Administrator
Valley View Healthcare & Rehab
510 East Cedar Street
Houston, MN 55943

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective October 3, 2018 the above facility is certified for:

45 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 45 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us
cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 16, 2018

Administrator
Valley View Healthcare & Rehab
510 East Cedar Street
Houston, MN 55943

RE: Project Number

Dear Administrator:

On September 19, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 29, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On October 3, 2018, the Minnesota Department of Health, completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 11, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 29, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 3, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 29, 2018, effective October 3, 2018 and therefore remedies outlined in our letter to you dated September 19, 2018, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 1D1E

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(L4) **510 EAST CEDAR STREET**
(L5) **HOUSTON, MN** (L6) **55943**

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1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/29/2018** (L34)

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2 AOA 3 Other

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03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

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To (b) :

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X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

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1861 (e) (1) or 1861 (j) (1): (L15)

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17. SURVEYOR SIGNATURE Date :
Angela Hatch, HFE NE II 10/04/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Sr. Health Program Rep 10/16/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
07/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered

September 19, 2018

Administrator
Valley View Healthcare & Rehabilitation
510 East Cedar Street
Houston, MN 55943

RE: Project Number S5566029

Dear Administrator:

On August 29, 2018, a standard 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. In addition, at the time of the August 29, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint number .

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby corrections are required. In addition, at the time of the August 29, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint number that was found to be unsubstantiated.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Nicole Osterloh, Unit Supervisor
Marshall District Office
Health Regulation Division
Licensing and Certification
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083
Fax: 507-537-7194

Maria King, RN, APM
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Mankato Place
12 Civic Center Plaza, Suite 2105
Mankato, Minnesota 56001-7789
Email: maria.king@state.mn.us
Phone: (507) 344-2716
Fax: (507) 344-2723

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 8, 2018, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 8, 2018 the following remedy will be imposed:

• Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. 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, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will

recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 November 29, 2018 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 1, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	08/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW HEALTHCARE & REHAB	510 EAST CEDAR STREET HOUSTON, MN 55943

(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
E 000	Initial Comments A survey with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 8/26/18 through 8/29/18 during a recertification survey. The facility is NOT in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed ensure the emergency preparedness	E 001	All staff will be trained on the Emergency Preparedness Plan at our in-services on	10/3/18

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

Electronically Signed | 09/28/2018

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	08/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 001	Continued From page 1 program included 1 of the 4 required components (training). There was no training completed for staff, residents, families, contracted staff, or volunteers. This had the potential to affect all 39 residents residing in the facility. Findings include: Review of the emergency preparedness (EP) plan included a policy and procedure for training and testing based on the facility's risk assessment. However, the facility had not implemented any training for staff, resident, family or persons who were providing services under arrangement, or volunteers. The administrator was interviewed on 8/29/18 at 11:11 a.m., and indicated he was not aware of the residents, families, contracted staff, or volunteers were trained or informed regarding the facility's EP program.	E 001	October 2nd and 3rd. Volunteers will each be given a P&P the next time they are in the facility for them to take home and review. Residents and family members will be notified of the plan on admission, and all current residents will be informed of the plan during activities the week of October 1st. Any residents who do not make the activity will be spoken with individually. The administrator will monitor that all staff, volunteers, residents and family are informed of the plan. He/she will audit monthly to ensure compliance for 6 months. Results will be given to the QI committee.	
E 036 SS=F	EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing	E 036		10/3/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	08/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW HEALTHCARE & REHAB	510 EAST CEDAR STREET HOUSTON, MN 55943

(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
E 036	Continued From page 2 program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on interview and policy review, the facility failed to ensure all staff, residents, families, contracted staff, or volunteers had been trained and/or informed on the emergency preparedness program. This had the potential to affect all 39 residents currently residing in the facility Findings include: Review of the emergency preparedness (EP) plan included a policy and procedure for training based on the facility's risk assessment. However, the facility had not implemented any training for staff, resident, family or persons who were	E 036	All staff will be trained on the Emergency Preparedness Plan at our in-services on October 2nd and 3rd. Volunteers will each be given a P&P the next time they are in the facility for them to take home and review. Residents and family members will be notified of the plan on admission, and all current residents will be informed of the plan during activities the week of October 1st. Any residents who do not make the activity will be spoken with individually. The administrator will monitor that all staff, volunteers, residents and family are	

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E 036	Continued From page 3 providing services under arrangement, or volunteers. The administrator was interviewed on 8/29/18, at 11:11 a.m. and indicated he was not aware of the residents, families, contracted staff, or volunteers were trained or informed regarding the facility's EP program.	E 036	informed of the plan. He/she will audit monthly to ensure compliance for 6 months. Results will be given to the QI committee.	
F 000	INITIAL COMMENTS On 8/26/18 through 8/29/18, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced	F 554		10/3/18

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F 554	Continued From page 4 by: Based on observation, interview, and document review, the facility failed to administer medication to 1 of 1 resident (R20) who had been deemed inappropriate to self- administer medication. Findings include: Review of R20's medical record indicated was admitted to the facility on 9/6/17 with diagnoses of upper left arm neuropathy (numbness), pneumonitis (lung inflammation), stroke, and colon and lung cancer. R20's annual Minimum Data Set (MDS), dated 7/26/18, identified R20 had intact cognition. Review of R20's current physician's orders identified an order on 2/16/18, for ipratropium-albuterol medication solution for nebulization; 0.5 milligram (mg) - 3 mg/3 milliliters (ml); Give one ampule four times a day as needed (PRN) in the morning, midday, evening, and bed time for cough. Nurses were to assess lung sounds during those administrations. There was no mention in R20's physician order for self-administration of medication. Observation on 8/27/18 at 9:47 a.m., of R20's room, revealed solution remained in R20's inhalation cup attached by tubing to his nebulizer machine (used to administer lung medication), located on his bedside table. R20 stated, "They just leave the nebulizer for whenever I feel like doing it". Further observations later that day indicated the nebulizer solution remained in that same inhalation cup at 2:20 p.m., and again at 3:54 p.m. Observation on 8/28/18 at 7:23 a.m., of R20's	F 554	F554 483.10 (c) (7) Resident Self- Admin Meds-Clinically Approp. The rights to self-administer medications if the interdisciplinary team, as defined by 483.2 (b) (2) (ii), has determined that this practice is clinically appropriate. Valley View Healthcare and Rehab ensures the right to self-administer medications if the interdisciplinary team, as defined by 483.21 (b) (2) (ii), has determined that this practice is clinically appropriate. R 20 was re-assessed by RN for self □administration of Medication on 8/29/18 and per interdisciplinary team resident was found to be appropriate for self-administration of the nebulizer after set up by nursing staff. Order obtained from MD and entered in to EMAR with care plan updated on 8/29/18. Self-Administration assessment policy was reviewed and updated on September 19th 2018. All RN charge nurses were provided with a copy of the updated policy. This will be reviewed on all new admissions, along with Quarterly, Annual and Significant change assessments. MDS coordinator will do a random audit of self-administration assessments and care plan to ensure that assessment is complete and accurate and care plan is up to date. Mandatory nursing in-service for review of updated policy will be provided on October	

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F 554	Continued From page 5 nebulizer machine indicated medication remained in the nebulizer cup. Observation and interview on 8/28/18 at 8:24 a.m., in R20's room with nursing assistant (NA)-B indicated the nurse was responsible for nebulizer administration. R20 would push the button when he needed to use it. NA- B agreed there had been a clear plastic ampule, labeled albuterol sulfate (medication for the lungs) lying next to the nebulizer machine. Interview on 8/28/18 at 8:27 a.m., with R20 indicated he had used his nebulizer daily. He would tell the nurse when he used it. R20 reported using it up to three times a day. Observation and interview on 8/29/18 at 9:33 a.m., with R20 revealed leftover medication once again remained in his nebulizer cup. R20 stated he had used his nebulizer three times on 8/28/18. Review of R20's 8/7/18, Self-Administration of Medication assessment, performed by registered nurse (RN)-C, indicated licensed staff were to administer all medications to R20. Medications were to be locked in medication cart. Review of R20's current medication administration record (MAR) revealed the last documented PRN administration of ipratropium-albuterol solution to R20 was on 8/25/18, at 1:14 p.m. There had been no documentation in the MAR of administration of the medication after 8/25/18. R20's care plan last revised 8/10/18, indicated staff were to administer ipratropium-albuterol solution related to difficulty breathing and an increase in secretions. There was no mention of	F 554	2nd and 3rd, 2018. The Results of this monitoring will be brought forward to the Quality Assurance committee.	

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F 554	Continued From page 6 R20 being approved to self-administer medication on the care plan. Review of the 11/29/05, Self-Administration policy defined the criteria for a resident to be able to self-administer medications included: (1) Licensed staff were to notify the MDS coordinator of the resident's request to self-administer medication. (2) The MDS coordinator was to complete a self-administration assessment. (3) The interdisciplinary team was to discuss and determine the resident's ability to self-administer medication. (4) The MDS coordinator would discuss the results of the assessment with the resident. (5) The nurse would then obtain a physician's order for self-administration of the specific medication, and educate the resident on the proper way of taking the medication, and appropriate use of the equipment. (6) The MDS coordinator would reassess the resident's ability to self-administer medication with a quarterly, annual significant change or PRN. (7) The care plan should be updated to reflect the resident's self-administration of medications/treatments.	F 554		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.	F 565		10/3/18

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F 565	Continued From page 7 (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure and act upon 10 of 10 residents' (R4, R8, R10, R11, R12, R15, R20, R23, R26, and R38) grievances addressed at resident council for in a timely manner. Findings include: Review of the Resident Council meeting minutes indicated on 3/2/18, on 4/6/18, 5/4/18, 6/8/18,	F 565	F565 483.10 (f) (5) (i)-(iv) (6) (7) Resident /Family Group and Response Valley View Healthcare and Rehab ensures that all residents have a right to organize and participate in resident groups in the facility. Policy was reviewed and updated on 9/24/18 to address that the policy of Valley View Healthcare and Rehab listen to all	

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F 565	Continued From page 8 7/6/18, and 8/27/18 revealed concerns/grievances were listed in the old business. There was no mention of the facility's response . 1.) Noise-no updates on concern 2.) Call light wait times-no updates 3.) Temperature in facility- cool in dining and activity room-no updates 4.) Menus: coffee not hot, longer wait times for meal service-no updates There had been no response to date from the appropriate department head, or an update/action on concerns/grievances by the facility documented in any of the above meeting minutes. Interview on 8/27/18 at 1:15 p.m., with resident council members revealed R20 would routinely attend the resident council meetings. R20 indicated the facility had not followed up with concerns/grievances at the previous meetings. Resident council members agreed they would like to receive responses from the appropriate managers related to the specific concerns voiced. R20 indicated the licensed social worker's (LSW) responsibility as the facility staff liaison, allowed by resident council members to attend, documented the meeting minutes and took those concerns to the appropriate department managers. Concerns and grievances had been repeatedly voiced during the council minutes. Those concerns were: (1) Noise levels in the facility as a result of staff conversations. (2) The want to obtain a facility dog. (3) Temperatures of foods being served. (4) Temperature of the hall ways. (5) Residents not receiving baths when scheduled.	F 565	concerns, individual and group, verbal and written. Resident council is held monthly and all residents are encouraged to attend. Facility staff helps residents to and from meetings. Grievances will be addressed in a timely manner. Following Resident council meeting, Advisor will pass concerns in writing to the appropriate manager of that department. The department that has been presented the concern will be asked to provide a written response to the concern. Furthermore, the department will put into action the changes that are needed. The resident council will be provided, at the next meeting, unless asked for a response sooner, the department response. The department responses will be put in the resident council minutes. If the response is not satisfactory or if the concerns are still an issue, the manager will be asked to come to the meeting to discuss further. Mandatory in-service for review of updated policy/procedure will be provided to staff on October 2nd and 3rd, 2018. Social Worker/Activities will monitor monthly that all concerns and or grievances are addressed and documented in monthly council minutes. The concerns and follow through will be brought forward to the Quality Assurance committee.	

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F 565	Continued From page 9 Residents agreed this was a concern as no explanations and/or plan of action from the facility had been provided. Interview on 8/28/18 at 11:36 a.m., with the LSW indicated she arranged and took minutes at the Resident Council meetings due to there not being a designated president per resident choice. She reviewed any concerns from the previous meeting with the group and documented any new concerns. Those new concerns were then addressed with the appropriate department manager, who was responsible to act on those items. The LSW agreed there was no documented response provided to the resident council included in the meeting minutes. The administrator was interviewed on 8/29/18 at 8:49 a.m.. He was unaware of more than one meeting in which concerns were brought forward. He had emailed the appropriate manager the concern and those managers had responded to him via email. The last email sent was about 6 weeks prior. The facility did not have a current practice of how a concern or grievance was to be addressed by the individual managers, how it had been resolved, or if the concern/grievance had been taken back to be reviewed at the resident council meeting. His expectation would be for managers to timely communicate back to the resident council on any concerns or grievances brought up at the meetings. There was no policy provided addressing resident council concerns/grievances and the method for resolution.	F 565		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v)	F 582		10/3/18

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F 582	Continued From page 10 §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any	F 582		

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F 582	Continued From page 11 deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) to 1 of 3 residents (R140) whose Medicare A coverage had ended. Findings include: Review of 140's medical record indicated he received services under Medicare from 7/5/18 through 7/20/18 was not provided appropriate notice of benefit ending for non-coverage indicating the resident or legal representative could request a reconsideration or demand bill, once Medicare services were no longer being received or necessary. There was no documentation to support the notice of non coverage had been provided 48 hours before coverage would be discontinued. Interview on 8/29/18 at 8:44 a.m., with social services designee (SSD)-A indicated she was responsible for providing the notice of non-coverage forms to resident or representative.	F 582	F582 483.10 (g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice Valley View Healthcare and Rehab ensure that the facility must-inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid/ Medicare. Policy was reviewed and updated on 9/24/18, to address that at the time of admission, all residents and/or their responsible party will be notified if they meet eligibility of Medicare coverage. If they are being admitted as a non-covered stay, they will be informed in writing, and will be asked to sign confirmation of this information. When a resident is admitted under a Medicare and/or HMO stay, facility staff (nursing, therapy, business office and/or social services) will help keep track of the number of days they	

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F 582	Continued From page 12 SSD-A indicated she could not find documentation in R140's medical record of the notice being given to R140 or their representative. Interview on 8/29/18, at 8:50 a.m., with the director of nursing (DON)-B indicated her expectation was SS-A would ensure the denial notices would be done for Medicare part A beneficiary notification and given in a timely manner. A policy for notification of non coverage was not provided during by the exit of survey.	F 582	have used in the current benefit period. When a resident has no skilled nursing coverage for continued stay, they will be notified in writing at least 48 hours in advance of going off the skilled level of care. The resident will be asked to sign confirmation of this information. The signed documents will be kept in the Business office files. Mandatory in-service for review of updated policy will be provided to staff on October 2nd and 3rd, 2018 Social Worker or in his/her absence the Business office, will monitor monthly for all Medicare covered residents that the latest notice is in file, signed and dated by resident or their responsible party. The results of this monitoring will be brought forward to the Quality Assurance committee.	
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;	F 625		10/3/18

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F 625	Continued From page 13 (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure residents and/or their representatives were informed of the facility bed hold policy at the time of hospitalization for 4 of 5 residents (R7, R19, R33, and R90) reviewed for a facility-initiated discharge. Findings include: R7 was admitted to the facility on 12/13/17, with diagnoses including Cerebral Vascular Accident (CVA), generalized pain, constipation, dysphagia (difficulty swallowing), osteoporosis, hyperlipidemia (high cholesterol), hypertension (HTN)(high blood pressure), depressive disorder, anemia and hypothyroidism. On 7/1/18 - 7/12/18, R7 was transferred to the hospital for diagnoses of sepsis and pneumonia. However, review of both the electronic medical record (EMR) and paper record lacked	F 625	F625- 483.15 (d) (1) (2) - Notice of Bed Hold Policy Before/Upon transfer. Valley View Healthcare and Rehab ensures a Bed-hold policy upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. Valley Views Hospital transfer policy was updated on 9/19/18; all licensed staff was provided with a copy of the updated policy. RN charge nurse will perform random audits on progress notes for residents that were transferred to the hospital or	

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F 625	Continued From page 14 documentation of R7 having received a bed hold notice within 24 hours of being transferred to the hospital on 7/1/18. R19 was transferred to the hospital during the dates of 7/20/18 - 7/24/18 with diagnoses of pulmonary embolism with acute cor pulmonale, congestive heart failure (CHF), long term use of anticoagulants, and diabetes. No documentation of a bed hold notice being provided within 24 hours of being transferred to the hospital was found in either the EMR or paper record. R33 was transferred to the hospital during the dates of 7/15/18 - 7/19/18, with diagnoses including suspected left hip fracture and hypertension. No documentation of a bed hold notice being provided within 24 hours of being transferred to the hospital was found in either the EMR or paper record. R90 was hospitalized during the dates of 6/9/18 - 6/11/18 with diagnoses including rectal bleeding and anemia. No documentation of a bed hold notice being provided within 24 hours of being transferred to the hospital was found in either the EMR or paper record. Review of the facility undated policy: Bed Holding Policy and Readmission: Resident that have been transferred for hospitalization or therapeutic leave, will be granted the option of holding a bed in accordance with the policy of Valley View Healthcare & Rehab. All Residents: The nursing home will notify the resident and if needed, the resident's legal guardian, on the 15th day for hospital leave, or the 33rd day for therapeutic leave, to determine the resident's option for holding a bed. If a resident does not agree to	F 625	therapeutic leave for proper documentation as stated in updated policy. Mandatory nursing in-service for review of updated policy will be provided to staff on October 2nd and 3rd, 2018. The results of this monitoring will be brought forward to the Quality Assurance committee.	

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F 625	Continued From page 15 hold a bed by means of private pay, the resident will be discharged on the 19th day if on hospital leave, or on the 37th day if on therapeutic leave. The written notice does not contain any documented contact of either the resident or resident representative when notice is provided.	F 625		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nail care was provided weekly or more often as needed for 1 of 5 residents (R29) with long, visibly dirty nails who was dependent on staff for assistance. Findings include: R29's was admiited on 5/3/17, with diagnoses of left upper humerus fracture (upper arm) healing, viral pneumonia, history of malignant neoplasm of the breast, gastro-esophagela reflux disease (heartburn), constipation, shortness of breath, hyperlipidemia (high cholesterol), macular degeneration (eye disease leading to blindness), hypertention and dry eye syndrome. R29's annual Minimum Data Set (MDS) dated 8/14/18, identified R29 to have moderate cognitive deficit and indicated R29 required one staff for extensive assist with personal hygiene. The Care Area assessment (CAA) dated 5/14/18, indicated R29 required the extensive assistance	F 677	F677 483.24(a) (2) ADL Care Provided for Dependent Residents Valley View Healthcare and Rehab ensures a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene as defined in 483.24(a) (2). Personal care and nail care policies were updated on 9/19/18; all Certified Nursing Assistants were provided with a copy of the updated policies. After notification CNA provided nail care for R29 and nails were trimmed and cleaned on 8/28/18. Director of Nursing or designee will provide weekly audits on 5 random residents to physically asses proper nail care was provided on bath day-weekly	10/3/18

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F 677	Continued From page 16 of one staff related to weakness, limitation in functional mobility and reliance on staff. R29's care plan dated 8/23/18, identified the need to have one person assist her with personal hygiene during bathing. R29's bath record revealed R29 received a bath on 8/23/18. At that time, staff indicated she had not needed nail care. Review of R29's bath sheet documentation dated 8/16/18, indicating where nail care was to have been documented as completed had been left blank. During observation on 8/27/18, at 9:18 a.m. R29 had dark colored dirt and debris caked underneath her overly long finger nails. During observation on 8/28/18 at 7:23 a.m. R29 was in her room being assisted with morning cares via two staff. R29 was observed to have long fingernails on both hands, with visible dirt/debris packed under each finger nail. During interview on 8/28/18, at 1:04 p.m. nursing assistant (NA)-D verified that residents get a bath at least once a week or more with nail care being done by bath aide. NA-D further indicated that any nursing assistant can do nail care anytime they notice it needs to be done. NA-D also indicated that activities does nail care with nail painting every Friday after mass. During interview on 8/28/18, at 2:25 p.m. NA-E verified that R29's nails were long with brown debris under each finger nail. R29 indicated nails were long and could be trimmed.	F 677	times one month, then monthly thereafter times 3 months. Mandatory nursing in-service for review of updated policies will be reviewed on October 2nd and 3rd, 2018 The results of this monitoring will be brought forward to the Quality Assurance committee.	

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F 677	Continued From page 17 During interview on 8/28/18, at 2:33 p.m. DON-B indicated she would expect that nail care is done on bath day or any day that staff noticed nails are dirty or needed trimming. During observation on 8/29/18, at 8:41 a.m. R29's nail were trimmed and cleaned. R29 indicated they came last night and cleaned and trimmed her nails, R29 further indicated she was very glad and then said they just never got it done before. The facility policy reguarding personal hygiene was requested but not provided during the survey.	F 677		
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 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:	F 688		10/3/18

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F 688	Continued From page 18 Based on observation, interview, and document review, the facility failed to follow interventions to maintain or improve range of motion (ROM) for 1 (R20) of 2 residents reviewed. Findings include: R20 was admitted to the facility on 9/6/17, with diagnoses of pneumonia, cough, lesion of radial nerve, hypertension (high blood pressure), major depressive disorder, cerebral infarction (stroke), chronic kidney disease, peripheral vascular disease (restricts blood flow to the leg muscles), history of lung cancer, malignant neoplasm (cancer) of large intestine-colon cancer, type 2 diabetes, displaced fracture of second cervical vertebra, and others. R20's annual minimum data set (MDS) dated 7/26/18, indicated R20 was cognitively intact, required extensive assistance of one with bed mobility, bathing, toilet use, transferring, walking in corridor, personal hygiene, locomotion on and off the unit. R20 required limited assist of one with walking in his room and was not steady, and was only stabilizing with the assistance of staff. R20 had functional limitations with ROM to the upper and lower extremities. R20's care plan dated 8/10/18, indicated decreased mobility in extremities and staff was noted to have had concerns with appropriate ambulation (walking). R20's goal was to maintain ROM in upper extremities (UE) and prevent any further decline using an exercise and restorative program. R20's ambulation was to maintain his ROM using a walking program. R20's interventions included: (1) Performing grooming and dressing in the	F 688	F688 483.25 (c) (1)-(3) Increase/Prevent Decrease in ROM/Mobility Valley View Healthcare and Rehab ensures that 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. Review of Restorative nursing policy and procedure on 9/20/18, updated to state if restorative is unavailable the certified nursing assistant that is assisting this resident will perform ROM and ambulation per care plan. Will train and certify more nursing assistants in the restorative program to ensure ROM and mobility are completed per resident care plan. Director of Nursing or designee will conduct audit on residents currently on restorative that their care plan is followed weekly times 1 month, then monthly times 3 months. Mandatory in-service for review of policy will be provided on October 2nd and 3rd, 2018 The Results of this monitoring will be brought forward to the Quality Assurance committee.	

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F 688	Continued From page 19	F 688		

bathroom with assistance from the restorative aide daily.
(2) Using one and two pound weights for UE exercises of elbow flexion (bending), using 10 repetitions (reps) per arm daily, forearm exercises 10 reps per arm daily, and wrist flexion 10 reps per arm daily.
(3) Use of the elliptical (machine used to mimic stair climbing, walking or running) 15 minutes daily to enhance or maintain his ROM with lower extremities (LE).
(4) To ambulate with the restorative aide per program while using a two-wheeled walker with a goal of ambulating 100-150 feet.

On 8/27/18 at 9:11 a.m., R20 stated, "We are supposed to have a restorative therapy program here 5-6 days a week and I get it done about one day a week. Every time they need an aide [certified nursing assistant (NA)] for something else, the program is gone". R20 had to start asking staff to walk with him.

On 8/29/18 at 9:30 a.m., R20 stated, "I didn't get it [restorative program] done yesterday and I don't know why. She [restorative aide] was here. I refuse it [restorative therapy] sometimes when I am sleeping but they don't ever come back and offer it to me again".

Restorative program participation logs from 7/28/18 to 8/24/18, indicated out of the 28 days reviewed, R20 refused four days, was not offered restorative 15 days, and received the restorative program as care planned 9 of 28 days.

Interview 8/29/18 at 9:38 a.m., with physical therapy assistant (PTA)-A and certified occupational therapy assistant (COTA)-B,

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F 688	Continued From page 20 indicated they talk to the restorative aides almost daily. When asked if the restorative aides have enough time to get the restorative programs done, PTA-A stated, "yes and no, depends on the day". Their expectation was to offer the restorative program again if a resident refuses initially. PTA-A and COTA-B had heard residents complaining about not getting their restorative programs done, especially on the weekends. Interview with restorative aide (RA)-A on 8/29/18 at 9:53 a.m., revealed there is not enough time to get all of the residents needing restorative therapy done. Restorative staff were getting reassigned to work in the facility to assist with resident care. Residents would ask for them to assist with exercises, but there just isn't enough time when working as a NA to get them done". RA-A confirmed restorative program were not done because RA's had been reassigned to work as a NA on the floor because of staffing issues. On 8/28/18 at 11:37 a.m., interview with the director of nursing (DON) confirmed there were two trained RA's. If RA's would get pulled to the floor, there are other days for them to make up resident's restorative program needs. Review of the Restorative Nursing Policy & Procedure dated 6/7/17, revealed the facility was responsible for restorative programs for residents to assist with attaining or maintaining their highest practicable physical, mental, and psychosocial well-being. The restorative program was available seven days a week and was provided for residents with assessed needs according to program criteria.	F 688		
F 755	Pharmacy Srvcs/Procedures/Pharmacist/Records	F 755		10/3/18

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F 755 SS=E	Continued From page 21 CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the contracted pharmacy failed to provide services to ensure emergency medications stored in the emergency medication kit (E-kit) were not	F 755	F755 483.45(a)(b)(1)-(3) Srvcs/Procedures/Pharmacist/Records Valley View Health care and Rehab will ensure that the facility must provide	

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F 755	Continued From page 22 expired. This had the potential to affect any residents who required the use of these medications. Findings include: Observation of the medication storage room on 08/28/18 at 10:45 a.m., with licensed practical nurse (LPN)-A, identified an E-kit labeled with the number 3. Inside the E-kit were individually labeled trays and locked trays. All trays had a list of medications affixed to the top lid to indicate tray contents. Observation of the medications in the E-kit identified two unlocked trays. Two medications were expired: an epinephrine (Epi-Pen), used for emergencies, had an expiration date of March 2018. Sulfadiazine (an antibiotic) had an expiration date July 2018. Interview with the DON-A on 08/28/18 at 1:06 p.m., indicated the facility emergency medications were managed by the contracted pharmacy. The contracted pharmacy's responsibilities included ensuring medications were stocked appropriately and had not expired. Contracted pharmacy staff and nursing staff were to ensure expired medications were removed prior to their expiration. Nursing staff were to notify the contracted pharmacy if they observed expired medications. Interview with pharmacy manager (PM)- A on 8/28/18 at 11:31 a.m., revealed facility E-kits were overseen and maintained by pharmacy. The E-kits were to be exchanged after the pharmacy received notified from nursing staff of medication removal. In the event nursing staff had not notified the pharmacy of the need to exchange or replace medication prior to exchange, E-kits	F 755	routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in 483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. Upon notification of expired medications found in E-kit, the contracted pharmacy was called and made aware. Expired medication was removed from the E-Kit and a new E-kit was delivered the evening of 8/28/18. New E-kit is a sticker that states the date that the first medication in this E-kit will expire. Medication storage policy was updated on September 20, 2018. All licensed staff and TMA□s have been provided a copy of the updated policy. Director of nursing or designee will complete monthly audits to the medication room to ensure all expired medications are removed. Pharmacy LPN consultant will perform monthly medication room audits. Mandatory nursing in-service for review of updated policy will be provided on October 2nd and 3rd, 2018 The results of this monitoring will be brought forward to the Quality Assurance committee.	

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F 755	Continued From page 23 exchange would occur monthly. When E-kits were restocked at the pharmacy, the expectation was expiration dates had been checked to ensure no expired medication remained. A policy/procedure for medication storage was not provided by the end of the survey.	F 755		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications (pantoprazole and omeprazole) were administered in a timely manner in accordance with physician's order for 2 of 6 residents (R20 & R23) observed for medication administration. Findings include: Review of R23's medical record indicated a diagnosis of gastroesophageal reflux disease (indigestion). R23's current physician order dated 8/7/18, indicated 40 milligrams (mg) of pantoprazole was to be administered orally every morning, 30 to 60 minutes before meals. During observation of medication administration on 8/28/18 at 7:16 a.m., licensed practical nurse (LPN)-B administered R23's pantoprazole. R23 was finished eating and had eaten 100% of her breakfast. R23's medication blister pack	F 759	F759 483.45 (f)(1) Free of Medication Error Rts 5 Prcnt or More. Valley View Healthcare and Rehab ensure that the facility is free of medication error rates of 5 prcnt or more as defined by 483.45 (f)(1). Upon review of medication times it was noted that not all Anti-ulcer medications had specific times to dose residents prior to meals. All orders were updated with specific times noted to ensure resident receives medications prior to meals for most effective use. All licensed staff and TMA□s have been provided a copy of the updated procedure. Medication Pass procedure was reviewed and updated 9/24/18 to state nursing staff must follow physician orders for medications.	10/3/18

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F 759	Continued From page 24 instructions for administration matched the above physician's order. Review of R20's medical record indicated a diagnosis of a history of peptic ulcer (hole in lining of the stomach). R20's current physician's order dated 7/11/18, indicated 20 mg of omeprazole was to be administered orally every morning, 30 to 60 minutes before meals. During observation of medication administration 8/28/18 at 7:18 a.m., LPN-B administered R20's omeprazole while R20 was eating breakfast. R20's medication blister pack instructions for administration matched the above physician's order. During an interview on 8/28/18 at 9:09 a.m., LPN-B was aware both R23 and R20 were supposed to receive their medication before meals according to physician's orders. It had been difficult to administer medications to R20 and R23 prior to meals. R20 and R23 would often come down for breakfast before morning medication pass. LPN-B agreed R20 and R23 should have received their medication prior to meals per R20 and R23's physician's orders. During an interview with the director of nursing (DON)-A on 8/28/18 at 1:06 p.m., the DON indicated it was her expectation staff were to administer any medication as directed by the physician's order. Review of the 5/3/18 Medication Pass Procedure indicated staff were to dispense medications according to instructions on the label. There was no mention of following physician's orders.	F 759	Director of Nursing or designee will perform weekly audit for one month, then monthly there after times three months that medications are administered as directed by the Physicians orders. Mandatory nursing in-service for review of updated procedure will be provided on October 2nd and 3rd, 2018 The results of this monitoring will be brought forward to the Quality Assurance committee.	

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	245566	A. BUILDING _____ B. WING _____	08/29/2018

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F 761	Continued From page 25	F 761		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure in-use medications were appropriately labeled for 5 of 39 residents (R3, R11, R19, R20 & R29) with an expiration date according to manufacturer's guidelines, located in 1 of 2 medication carts. Findings include:	F 761	F761 483.45 (g) (h) (1) (2) Label/Store Drugs and Biological Valley View Healthcare and Rehab will ensure labeling of drugs and Biologicals Drugs used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	10/3/18

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F 761	Continued From page 26 Observation of East wing medication cart and interview with licensed practical nurse (LPN)-A on 08/26/18 at 6:35 p.m., identified several eye drops and 1 inhaled medication currently in-use, were not labeled appropriately with an opened and/or expiration date. (1) R3's had 3 opened bottles of Systane (artificial tears) eye drops. All three bottles had no opened dates. LPN-A was unable to determine when the bottles were opened or expired. (2) R11's Advair discus (inhaler) had no opened date on the inhaler. Manufacturer's instructions indicated staff were to discard the medication 30 days after opening. R11 had 1 bottle of Latanoprost (glaucoma medication) and 1 bottle of Systane eye drops. There was no open dates written on the those bottles. LPN-A was unable to determine when the bottles were opened or expired. R11's dorzolamide/Timolol (glaucoma medication) had an open date of 7/19/18. LPN-A agreed that bottle had expired after 30 days of opening. (3) R19's Advair Discus had no open date or expiration date. Manufacturer's instructions directed staff to discard the inhaler 30 days after opening. LPN-A was unable to determine when the inhaler was opened or when it had expired. (4) R20's Natural Tears eye drops were dated 7/9/18. LPN-A agreed eye the drops were expired as it was outside the 28 day recommended range. (5) R29's Refresh Tear eye drops were marked as opened on 7/19/18. LPN-A agreed eye the drops were expired as it was outside the 28 day recommended range. During an interview on 8/26/18 at 7:10 p.m., trained medication aid (TMA)-B indicated all eye drop and inhalers should have been dated with an	F 761	instructions, and the expiration date when applicable. Medication Expiration dating policy and procedure was updated on 9/20/18. All licensed staff and TMA□s were provided a copy of the updated policy. Director of Nursing or designee will complete random audits on the medication carts to ensure all medication□s that require a Date Opened is dated , and if noted beyond their expiration date are removed and reordered per policy. Pharmacy LPN consultant will perform monthly medication cart audits. A mandatory nursing in-service for review of updated policy will be provided on October 2nd and 3rd, 2018 The results of this monitoring will be brought forward to the Quality Assurance committee.	

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F 761	Continued From page 27 opened date. If a medication had no opened date, they should be replaced upon discovery. During an interview on 8/28/18 at 1:06 p.m., the director of nursing (DON)-A revealed eye drops and inhalers should be dated upon opening. Nursing staff had a posted reference regarding the dating of newly opened medication. DON-A expected staff to label medications when opened and check for expired dates on the label before administering medication. The director of nursing (DON)-A agreed the above mentioned medication was expired or labeled inappropriately. During interview on 8/29/18 at 11:20 a.m., the consulting pharmacist manager indicated medications needed to have opened dates. Opened medication expiration dates may differ from the manufacturer's. The consultant pharmacy attached stickers to prescription medications for staff to document when the medication had been opened. Audits were to be performed monthly by pharmacy staff to identify unlabeled, outdated and expired medications. There was no policy regarding the labeling of medications provided by the end of the survey.	F 761		

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K 000	INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (Valley View Nursing Home) was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and	K 000	EPOC	

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

Electronically Signed — 09/28/2018

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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K 000	Continued From page 1 Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Valley View Nursing Home is a 1-story building with no basement. The building was constructed at 4 different times. The original building was constructed in 1967 and was determined to be of Type II(111) construction. In 1976, addition was constructed to the West Wing that was determined to be of Type II(111) construction. In 1988, another addition was added to the South Wing and was determined to be Type II (111). In 2011 another addition was built to the NE corner of the existing building. Because the original building and the 3 additions are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 45 beds and had a census of 38 at the time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (18.3.5.12, 19.3.5.12, NFPA 10) This deficient practice could affect the safety of all (38) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 02:00 PM and 06:00 PM on 08/27/2018, observations and staff interview revealed, or observation and documentation reviewed revealed the following: Documentation review indicated that the Facility did not records available for review associated for the most recent annual fire extinguisher inspection This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 355	Resolution: Dean Johnson Valley View Maintenance Director obtained proper records from A-2 Fire protection and on file at facility. This was completed on August 28th, 2018.	8/28/18
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101	K 363		8/28/18

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K 363	Continued From page 3 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by:	K 363		

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K 363	Continued From page 4 The facility failed to comply with Life Safety Code (19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485) This deficient practice could affect the safety of all (38) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 02:00 PM and 06:00 PM on 08/27/2018, observations and staff interview revealed, or observation and documentation reviewed revealed the following: Observation during the inspection that the Kitchen - Fire Door did not close and latch properly when tested. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 363	Resolution: Dean Johnson Valley View Maintenance Director sanded portion of kitchen fire door until there was enough clearance for the door to latch properly. Door was reinstalled in kitchen. This was completed on August 28th, 2018.	
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by:	K 511		8/28/18

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K 511	Continued From page 5 The facility failed to comply with Life Safety Code (18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2) This deficient practice could affect the safety of all (38) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 02:00 PM and 06:00 PM on 08/27/2018, observations and staff interview revealed, or observation and documentation reviewed revealed the following: Observation during the inspection revealed unsecured electrical panels in resident corridors This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 511	Resolution: Dean Johnson Valley View Maintenance Director immediately obtained locks and locked all breaker boxes that were noted unsecure. This was completed on August 28th, 2018	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general	K 920		9/20/18

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K 920	Continued From page 6 precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5) This deficient practice could affect the safety of all (38) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 02:00 PM and 06:00 PM on 08/27/2018, observations and staff interview revealed, or observation and documentation reviewed revealed the following: Observation during the inspection that resident rooms: 15 and 105 had electrical multi-tap devices plugged into wall outlets. Documentation was not available to verify that the multi-tap devices were UL 1363 or UL60601 compliant. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 920	Resolution: Dean Johnson Valley View Maintenance Director contacted a licensed Electrician on August 28th,2018 to install more outlets in all resident rooms. Valley View is on the schedule for October. Removal of all non-complaint devices was completed September 19th,2018.	
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage	K 923		8/28/18

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K 923	Continued From page 7 Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99))	K 923	Resolution: Dean Johnson Maintenance Director and Nursing removed all card	

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K 923	Continued From page 8 This deficient practice could affect the safety of all (38) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 02:00 PM and 06:00 PM on 08/27/2018, observations and staff interview revealed, or observation and documentation reviewed revealed the following: Observation during the inspection revealed mixed storage of O2 cylinders in the storage racks in the Oxygen Storage Rm This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 923	board boxes in oxygen room, proper labeling placed for empty and full cylinders, all empty and full cylinders were placed in proper racks. This was completed on August 28th, 2018.	