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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 1UXN

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00442

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245373**

2.STATE VENDOR OR MEDICAID NO.
(L2) **537342500**

3. NAME AND ADDRESS OF FACILITY
(L3) **PELICAN VALLEY HEALTH CENTER**
(L4) **211 EAST MILL AVENUE**
(L5) **PELICAN RAPIDS, MN** (L6) **56572**

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 **12/24/2014** (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)
12/31

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

12.Total Facility Beds **40** (L18)

13.Total Certified Beds **40** (L17)

10.THE FACILITY IS CERTIFIED AS:

X 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
___ 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: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	40			
(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 :
Tammy Williams, HFE NEII 01/03/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 02/03/2015 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 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
12/01/1986
(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
12/15/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245373

February 3, 2015

Ms. Barbara Garrity, Administrator
Pelican Valley Health Center
211 East Mill Avenue
Pelican Rapids, Minnesota 56572-0645

Dear Ms. Garrity:

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 December 7, 2014 the above facility is certified for:

40 Skilled Nursing Facility Beds

Your facility's Medicare approved area consists of all 40 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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

January 6, 2015

Ms. Barbara Garrity, Administrator
Pelican Valley Health Center
211 East Mill Avenue
Pelican Rapids, Minnesota 56572-0645

RE: Project Number S5373027

Dear Ms. Garrity:

On November 24, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 7, 2014. 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 December 24, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on December 18, 2014 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 November 7, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 7, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 7, 2014, effective December 7, 2014 and therefore remedies outlined in our letter to you dated November 24, 2014, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245373	A. Building B. Wing	12/24/2014

Name of Facility	Street Address, City, State, Zip Code
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0325** Reg. # **483.25(i)** LSC	**12/07/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	**12/05/2014**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GA/mm	01/03/2015	32608	12/24/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
11/7/2014			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245373	A. Building B. Wing 01 - MAIN BUILDING 01	12/18/2014

Name of Facility	Street Address, City, State, Zip Code
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0075	Correction Completed 11/26/2014	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/mm	01/06/2015	27200	12/18/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 11/6/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 1UXN

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00442

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245373**
2.STATE VENDOR OR MEDICAID NO.
(L2) **537342500**

3. NAME AND ADDRESS OF FACILITY
(L3) **PELICAN VALLEY HEALTH CENTER**
(L4) **211 EAST MILL AVENUE**
(L5) **PELICAN RAPIDS, MN** (L6) **56572**

4. TYPE OF ACTION: **2** (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 **11/07/2014** (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)
12/31

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

12.Total Facility Beds **40** (L18)

13.Total Certified Beds **40** (L17)

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	40			
(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 :
Patricia Bernstetter, HFE NEII 12/12/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 12/15/2014 (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
12/01/1986
(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
Posted 12/15/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 6573

November 24, 2014

Ms. Barbara Garrity, Administrator
Pelican Valley Health Center
211 East Mill Avenue
Pelican Rapids, Minnesota 56572-0645

RE: Project Number S5373027

Dear Ms. Garrity:

On November 7, 2014, 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.

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 attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.
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;

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 a "F" tag), i.e., the plan of correction should be directed to:

Gail Anderson, Unit Supervisor
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Gail.anderson@state.mn.us

Phone: (218) 332-5140
Fax: (218) 332-5196

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 December 7, 2014, 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 December 7, 2014 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 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 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 February 7, 2015 (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 May 7, 2015 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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 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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0525

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5373s15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	11/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (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 form 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.	F 000		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to identify significant weight loss and initiate interventions to prevent weight loss for 1 of 3 residents (R4) reviewed for nutrition. Findings include:	F 325		

12/12/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 12/4/14

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.

RECEIVED
DEC 08 2014
MN Dept of Health
Fergus Falls

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	11/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 1 The Physician's Progress note dated 10/7/14, identified R4's diagnoses included dementia, GERD (gastro-esophageal reflux disease) and diabetes mellitus. R4's annual Minimum Data Set (MDS) dated 6/19/14, identified R4 required extensive assistance for all areas of daily living including transfer, personal hygiene, dressing and eating. The corresponding Care Area Assessment (CAAs) identified R4 had long and short-term memory problems, difficulty making decisions, inattention, and disorganized thinking related to dementia, organic brain syndrome and hearing loss. R4 received a regular type 2 no added salt diet and regular type 3 diabetic diet, with food textures to be as tolerated. The CAA indicated R4 was able to feed herself at times, but also needed assistance with eating, as needed (PRN). R4's appetite was identified as sporadic with snacks between meals encouraged to help maintain weight and ensure nutritional status. R4's care plan dated, revised 2/7/14, identified R4 had potential altered nutritional status due to diabetes and GERD and identified R4's goal was to have no significant weight changes. The interventions directed to provide regular texture diet as tolerated, assist with setup of the meal cutting, arranging foods and applying condiments. The care plan directed staff to offer snacks and fluids between meals. Further, the care plan directed to provide R4 with verbal cues, encouragement and to provide assistance with eating PRN. The care plan directed staff to monitor weight as ordered and observe intake for changes and address concerns PRN. R4's Nutritional Status Assessment dated	F 325	• Documentation regarding if all residents accepted morning, afternoon, and bed time snack to be monitored with ADL charting. o Completion date: 12/3/2014 • RD reviewed. Recommended diet texture change to pureed diet due to noted pocketing with meal intake observation for resident (R4). o Completion date: 11/25/2014 • RD will review and assess resident's (R4) nutritional status initially, and will reassess monthly until weight stable x3 months. o Completion date: 12/7/2014 initiated, ongoing • RD to review all resident monthly weights initially, and every month and communicate significant weight changes to charge nurse. RD will provide recommendations upon completion of each significant weight loss assessment is completed o Completion date: 12/7/2014 initiated, and ongoing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	11/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 2 6/19/14, identified R4's height was 65 inches. The assessment identified R4 was on routine weights, and had weight was done 7 lbs from January 2014 and identified R4 was sometimes willing to feed self, and other times R4 was not and would not let staff help her either. The assessment listed R4 was on type 2 and type 3 diet with textures as tolerated and directed to encourage snacks/nourishment between meals. No further nutritional assessments after 6/19/14 were found in the record. The facility form titled Vital signs and Weight Record identified the following: R4's weight 180 days prior on 5/21/14, was 136 pounds (lbs); R4's weight 90 days prior on 9/10/14, was 126 lbs; R4's weight 30 days prior on 10/1/14, was 124 lbs; R4's most current weight on 11/4/14, was 120 lbs (which was 16 lbs less than on the first date or a 13.3% weight loss). The form listed directions for staff to identify if there was a weight gain or weight loss between new and previous weight. If a weight change was identified utilizing the parameters on the bottom of the page, dietary and the nurse manager were to be notified. The bottom of the form identified a weight loss of 10% as a significant weight loss and a loss of greater than (>) 10% as "Severe" weight loss. Review of R4's dietary intake 10/7/14, through 11/5/14, identified R4 had variable intake for meals from 100% to refusal of all foods, with no pattern noted. The dietary intake lacked documentation of any snacks provided and the intake of those snacks.	F 325	Responsible for Correction & monitoring: Kara Oakes, RDLD, Dietary Director. RD will audit weights weekly for the month of December and then after that, monthly for three months and the findings of any audits will be presented to the QAPI team for review. Audits will be discontinued at the recommendation of QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	11/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 3 During an observation on 11/06/2014, at 8:18 a.m. R4 was seated in a wheelchair at a round table with two other female residents. At 8:24 a.m. R4's meal was placed on the table and consisted of a bowl of oatmeal served with half and half, one piece of buttered toast with jelly, a 4 ounce (oz) glass of juice, 6 oz glass of water, and an 8 oz cup of coffee. The assistant director of nursing (ADON)-C immediately sat at R4's table to assist R4 with the meal. ADON-C then cut R4's foods in to bite size pieces, offered R4 a drink of juice by bringing the glass to R4's mouth. ADON-C assisted R4 to eat oatmeal and offered fluids between bites. R4 remained alert throughout the breakfast meal, however, R4 did not attempt to feed herself. R4 shook her head back and forth when no more of an item was wanted. R4 consumed 100% of the breakfast foods and fluids. At 8:24 a.m. ADON-C confirmed R4's breakfast meal and stated, "[R4] can use a little extra calories." On 11/6/14, at 12:22 p.m. the director of nursing (DON) confirmed R4's fluctuation in dietary intake for 10/7/14, through 11/5/14. The DON stated R4's refusal to eat some meals was "not a new problem." On 11/6/14, at 1:47 p.m. the registered nurse (RN)-B confirmed R4 did not receive a dietary supplement, and none was listed to be given on the current medication administration record. On 11/7/14, at 8:07 a.m. R4 was observed to be seated in a wheelchair at a round dining room table. A staff member was seated next to R4 assisting with the meal, R4 independently handled the 4 oz juice glass.	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	11/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 4 On 10/7/14, at 10:43 a.m. RN-A confirmed R4 had cognitive impairment and stated R4 had a varied appetite, "but pretty ok." RN-A verified R4 did not receive a dietary supplement and indicated dietary staff were in charge of supplying residents snacks. On 10/7/14, at 10: 46 a.m. the nursing assistant (NA)-A stated R4's meal intake was dependent upon R4's mood. NA-A stated when R4 had poor dietary intake the nursing assistants "reported this" to the nurse. NA-A stated "the nurse will make sure she gets something later." On 11/7/14, at 11:12 a.m. RN-C confirmed R4 had a recent weight loss, and verified there was no documentation of a dietary or nursing evaluation for weight loss. RN-C stated the process for resident weight management was as follows: one nursing assistant would be responsible to weight all residents and document the results. If a weight loss of 3 lbs was noted by that nursing assistant, a note would be given to nursing to follow up. RN-C stated, "4 lbs is significant" weight loss and we would call the dietitian and get an order for a nutritional supplement. RN-C stated, "We would always implement a supplement." RN-C confirmed R4's record lacked a nutritional assessment and interventions to prevent further weight loss. On 11/7/14, at 11:20 a.m. DON stated the usual procedure to manage weight loss would have been the nursing assistant checking resident weights, would notify the nurse, and the dietary manager would have reviewed the weights. The nurse or dietary manager would then communicate with the dietitian. DON confirmed R4's significant weight loss and stated the	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	11/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 5 dietitian and physician "should have been notified." DON stated, "I believe [R4] fell through the cracks." The facility policy titled Weighing and Measuring the Resident dated as revised on 5/2011, identified a significant weight loss/gain was defined as greater than 5% difference in 30 days or greater than 7.5% difference in 90 days.	F 325	• Infection Control Coordinator to review all 24 hour nursing reports. o Completion date: 11/26/2014, ongoing. • Charge nurse to complete Infectious Symptom Report, and give to Infection Control Coordinator to notify of any infectious resident symptoms. o Completion date: 12/5/2014, ongoing • Infection Control Coordinator to track all resident's with infectious symptoms on monthly symptom tracking log o Completion date: 12/5/2014, ongoing • Any resident on infectious symptom tracking log that is later noted to have an active, diagnosed infection will be tracked on currently used infection control log. o Completion date: 12/5/2014, ongoing • If cultures are ordered, all culture results will be obtained, documented on the resident infection control log, and placed in resident chart by Infection Control Coordinator. o Completion date: 12/5/2014, ongoing	
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	11/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 6 hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to establish an infection control program which included comprehensive surveillance of resident symptoms, analysis of the surveillance, and investigation of patterns identified through the analysis. This had the potential to affect all 28 of 28 residents who resided in the facility. Findings include: Review of the facility forms titled Monthly Infection Log, January 2014 through November 2014, listed the room number, resident name, the site of infection, symptoms, and the antibiotic used for treatment. The logs identified three types of infection sites, UTI (urinary tract infection), skin, and respiratory. However, the log lacked documentation of any culture results identifying the specific pathogen (infectious agent). The log lacked documentation of infections prior to antibiotic treatment, diseases or infections which were not treated with antibiotics. The facility form titled Pelican Valley Health Center QA (quality assurance) Mandated	F 441	• Infection Control Coordinator to monitor any & all staff and residents with noted infectious symptoms to track and trend any possible correlation. o Completion date: 12/5/2014, ongoing Nursing will audit to ensure proper procedures are being followed in regards to tracking infections. Audits will be done weekly for the month of December and then after that, monthly for three months and the findings of any audits will be presented to the QAPI team for review. Audits will be discontinued at the recommendation of QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	11/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 7 Indicators, dated 2014, identified the number of residents who received antibiotics each month for UTI, respiratory and skin conditions. The log lacked documentation of specific pathogen and the proximity of the residents with infections. On 11/5/14, at 2:18 p.m. the assistant director of nursing (ADON)-B stated the procedure for the infection control program was to "Keep a running log of the antibiotics people are on... keep a little visual of where they are in the building...eventually." ADON-B stated the monthly log was transferred to the Pelican valley Health Center QA Mandated Indicators, and then brought to the quality assurance meetings (QA). ADON-B stated infection control monitoring was completed as needed and dependent upon "how often we are getting notice of people on antibiotics." ADON-B explained the process for staff to report infections was as follows: when an antibiotic was ordered staff followed a green sheet/check list. The check list directed staff to fill out an undated facility form titled resident Infection Report. ADON-B stated, "As the slips come in I look at them." ADON-B stated the infection control log was generated by antibiotic use and further verified no documentation would occur unless the resident was treated with an antibiotic. ADON-B verified residents who had developed shingles were documented on the infection control log; however, were not included on the monthly QA report. ADON-B verified no facility residents contracted influenza last year; however, influenza would not have been documented on the infection control logs, because influenza was not treated with antibiotics. On 11/6/14, at 11:55 a.m. ADON-B stated the	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	11/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 8	F 441		

infection control log "tracking begins with the note (Resident Infection Report) from the antibiotic order" at that time the signs and symptoms such as cough or fever, or what lead to the resident needing a culture, would have been written on the report sheet. ADON-B verified specific pathogens were not tracked, such as if the antibiotic order changed due to a culture result. ADON-B stated then a new report slip would be filled out by staff and given to ADON-B; however, if the antibiotic remained the same, ADON-B was not updated on the culture results. ADON-B verified infection control surveillance did not include the identified cause of the infections and stated we "don't generally talk about what is causing it... will report an increase in UTI's and then what teaching had been done... will specify UTI or skin." ADON-B verified staff instruction of hand washing, providing personal cares, or encouraging residents fluid intake were generated due to an increase of residents with UTI's rather than because of what pathogen the culture result identified.

On 11/6/14, 12:09 p.m. the director of nursing (DON) stated ADON-B was expected "to track and trend resident illnesses... where in the building, signs and symptoms, and the diagnoses." DON verified the infection control logs should include diagnoses, dates of onset of signs and symptoms, along with those specific signs and symptoms. DON verified the infection control log documentation should begin when residents showed signs and symptoms of infection such as a prolonged cough, multiple episodes of diarrhea. DON stated the infectious agent needed to be identified, when applicable. DON stated infections such as influenza and pneumonia not treated with an antibiotic were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING _____ B. WING _____	11/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 9 expected to be tracked. DON agreed the current facility infection control process was not adequately tracking and trending all infections. The facility policy titled Infection Control and Prevention Program dated as reviewed 5/2011, identified, "The facility develops, implements, and maintains an infection Prevention and Control Program in order to prevent , recognize and control, to the extent possible, the onset and spread of infection within the facility." The facility policy titled Infection Control Surveillance dated as reviewed 5/2011, identified, "Policy: Signs and symptoms of infection are continually monitored. -Purpose: To identify infections at onset so the appropriate treatment and infection control procedures can be put in place; to control outbreaks of infectious disease. -Procedure: 1. Daily: all residents are monitored for current signs/symptoms of infection and infection risk. 2. Monthly: The monthly report includes a compilation of the infection data. 3. Quarterly: Infection /data reports are reviewed by the Q/A committee."	F 441		

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

F5373024

PRINTED: 11/24/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY 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 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 Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Pelican Valley Health Center 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 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 Street, Suite 145 St. Paul, MN 55101 Or by e-mail to:	K 000	POC ok JB 12-10-14 RECEIVED DEC - 8 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

Exit: 11-7-14
Do: 12-7-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Executive Director

(X6) DATE: 12/4/14

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
	245373	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Marian.Whitney@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 The Pelican Valley Health Center was constructed at 4 different times and is a 1-story building without a basement. In 1951 the original building was built and was determined to be of Type II(111) construction (it is the lower level of the with a clinic building). In 1969 the majority of the building was constructed to the west and north of the clinic building and was determined to be Type II (000) construction. In 1996 a business office/ family room addition was constructed to the north of the 1969 building and was determined to be Type II (111) construction. A connecting link to the assisted living apartment building to the north was constructed in 2002 north of the 1996 addition and was determined to be Type V (111) construction and is separated from the assisted living with 2-hour fire rated barrier. The building is divided into 3 smoke zones with at least 30 minute fire barriers. The building is completely sprinkler protected in accordance with NFPA 13 Standard for the	K 000	• Signage noted on shower room door for staff reference. o Completion date: ~~12/3/2014~~ • Education to be provided to all staff when they are in the building to report for work. o Completion date: ~~12/3/2014~~ initiated, ongoing • All linen containers and trash containers not in use, are to be stored in designated, fire rated soiled linen rooms o Completion date: 11/26/2014 Responsible for Correction & monitoring: Mark Neu, Environmental Services Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 Installation of Sprinkler Systems 1999 edition. The facility has a manual fire alarm system with corridor smoke detection in the 1969 and 1996 building in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. Additional automatic fire detection is provided in all rooms required by the Minnesota State Fire Code 2007 edition and is monitored for automatic fire department notification. The facility has a capacity of 40 beds and had a census of 28 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 075 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has failed to store large trash and linen carts in properly protected rooms in accordance	K 075		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/06/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	**211 EAST MILL AVENUE** **PELICAN RAPIDS, MN 56572**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 075	Continued From page 3 with the NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.7.5.5. This deficient practice could affect the safety of all residents, staff and visitors if smoke or fire from one of these carts rendered the corridors untenable. Findings include: On facility tour between 10:30 PM and 1:30 PM on 11/06/2014, it was found in that the facility was storing multiple mobile solid linen and trash container that are greater than 32 gallons in aggregate in spaces that are greater than 64 square feet (in area) and that are open to the corridors and not in the required hazardous storage areas. This was confirmed by the Facility Administrator (BG).	K 075		