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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 4H57

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00121

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245442**

2. STATE VENDOR OR MEDICAID NO. (L2) **046545300**

3. NAME AND ADDRESS OF FACILITY
(L3) **SPRING VALLEY CARE CENTER**
(L4) **800 MEMORIAL DRIVE**
(L5) **SPRING VALLEY, MN** (L6) **55975**

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 **7/3/2016** (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 **50** (L18)

13.Total Certified Beds **50** (L17)

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

B.IIINotIinICmplianceIwithIProgram 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
	50			
(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 : 7/13/I6 (L19)
Gary Nederhoff, Unit Supervisor

18. STATE SURVEY AGENCY APPROVAL Date: 7/I3/20I6 (L20)
Kamala Fiske-Downing, Health Program Representative

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 **03/01/1987** (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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245442

July 12, 2016

Ms. Penny Solberg, Administrator
Spring Valley Care Center
800 Memorial Drive
Spring Valley, MN 55975

Dear Ms. Solberg:

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 June 30, 2016 the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 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, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 12, 2016

Ms. Penny Solberg, Administrator
Spring Valley Care Center
800 Memorial Drive
Spring Valley, MN 55975

RE: Project Number S5442027

Dear Ms. Solberg:

On May 27, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 18, 2016. 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 July 3, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 5, 2016 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 May 18, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 30, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 18, 2016, effective June 30, 2016 and therefore remedies outlined in our letter to you dated May 27, 2016, 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, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245442 Y1	A. Building B. Wing Y2	7/3/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	800 MEMORIAL DRIVE SPRING VALLEY, MN 55975

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0312	Correction	ID Prefix F0323	Correction	ID Prefix F0425	Correction
Reg. # 483.25(a)(3)	Completed	Reg. # 483.25(h)	Completed	Reg. # 483.60(a),(b)	Completed
LSC	06/26/2016	LSC	06/26/2016	LSC	06/26/2016
ID Prefix F0431	Correction	ID Prefix F0441	Correction	ID Prefix F0463	Correction
Reg. # 483.60(b), (d), (e)	Completed	Reg. # 483.65	Completed	Reg. # 483.70(f)	Completed
LSC	06/26/2016	LSC	06/27/2016	LSC	06/27/2016
ID Prefix F0465	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.70(h)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	06/27/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GPN/kfd	7/12/2016	10160	7/3/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
5/18/2016	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245442	A. Building 01 - MAIN BUILDING 01 B. Wing	7/5/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	800 MEMORIAL DRIVE SPRING VALLEY, MN 55975

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0054	Correction Completed 06/26/2016	ID Prefix Reg. # NFPA 101 LSC K0074	Correction Completed 06/26/2016	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 (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/kfd	7/12/2016	37008	7/5/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
5/18/2016	☐ 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245442	A. Building 02 - SPRING VALLEY CARE CENTER B. Wing	7/5/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	800 MEMORIAL DRIVE SPRING VALLEY, MN 55975

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0054	Correction Completed 06/26/2016	ID Prefix Reg. # NFPA 101 LSC K0074	Correction Completed 06/30/2016	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 (INITIALS) TL/kfd	DATE 7/12/2016	SIGNATURE OF SURVEYOR 37008	DATE 7/5/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
5/18/2016	☐ 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: 4H57

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00121

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245442**

2. STATE VENDOR OR MEDICAID NO. (L2) **046545300**

3. NAME AND ADDRESS OF FACILITY
(L3) **SPRING VALLEY CARE CENTER**
(L4) **800 MEMORIAL DRIVE**
(L5) **SPRING VALLEY, MN** (L6) **55975**

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 **05/18/2016** (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 **50** (L18)

13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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
	50			
(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 : 06/02/2016 (L19)
Christina Smith, HFE NE II

18. STATE SURVEY AGENCY APPROVAL Date: 07/12/2016 (L20)
Kamala Fiske-Downing, Health Program Representative

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 **03/01/1987** (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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 27, 2016

Ms. Penny Solberg, Administrator
Spring Valley Care Center
800 Memorial Drive
Spring Valley, MN 55975

RE: Project Number S5442027

Dear Ms. Solberg:

On May 18, 2016, 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;**
>
> **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 a "F" tag), i.e., the plan of correction should be directed to:

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

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 June 27, 2016, 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 June 27, 2016 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 August 18, 2016 (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 November 18, 2016 (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
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Feel free to contact me if you have questions.

Sincerely,

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245442	A. BUILDING _____ B. WING _____	05/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	800 MEMORIAL DRIVE SPRING VALLEY, MN 55975

(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. 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 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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 a resident received grooming assistance for fingernail care for 1 of 3 residents (R3) reviewed for activities of daily living (ADLs). Findings include: R3's quarterly Minimum Data Set (MDS) assessment dated 4/26/16, indicated the resident required extensive assistance with personal hygiene and had severe impairment. R3's	F 312	PLAN OF CORRECTION 5/24/2016 F 312 ¿483.25(a)(3) 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. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? For resident (R3) the written care plan was reviewed and Point of Care	6/26/16

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

Electronically Signed | 05/31/2016

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F 312	Continued From page 1 admission record, dated 5/18/16, included diagnoses of mild cognitive impairment. R3's care plan dated 2/10/16, indicated self-care performance deficit with rehabilitation potential related to limited mobility with interventions of bathing: check nail length and trim and clean on bath day and as necessary and requires one staff participation with bathing. On 5/16/16, at 2:25 p.m., R3's fingernails were observed to have dark brown/black debris under long nails on both hands. On 5/17/16, at 11:07 a.m., R3's fingernails on both hands were observed to have black debris under multiple fingernails and were untrimmed. On 5/17/16, at 11:09 a.m., R3 stated regarding his fingernails stated to surveyor that they need cutting, do you have time to cut them? On 5/18/16, at 12:47 p.m., registered nurse (RN)-A observed R3's fingernails on both hands and stated to R3 your fingernails need trimming and cleaning. RN-A verified R3's fingernails had black debris underneath multiple nails and were untrimmed. RN-A stated resident fingernails were trimmed and cleaned on resident bath days or sooner if needed. At 12:59 p.m., RN-A stated the nursing assistants were responsible for trimming and cleaning R3's fingernails. On 5/18/16, at 1:08 p.m., the director of nursing (DON) stated the facility system to have resident nails trimmed and cleaned was on bath days. More often if needed between baths. The DON stated she would expect staff to trim and clean nails prior to bath day if needed.	F 312	task was scheduled for each shift to check fingernails for cleanliness and length. Resident□s fingernails were checked by Director of Nursing Services on 5/24/16, and nails were trimmed and clean. Completed 5/24/16 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents who are at risk are any residents who are unable to complete their own nail care and any future admissions who are unable to complete their own nail care. Point of Care Group Update was completed on 5/24/16 to ensure documentation takes place on each resident in the facility each shift for checking of fingernail cleanliness and need for trimming. Record review, policy review and corrections were completed on 5/24/16. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Language and schedule of documentation was changed in Point of Care task library so that specific entry is required each shift on cleaning/trimming of finger nails. Completed 5/24/16. Activity department will also include males in their nail care program. How the facility plans to monitor its performance to make sure that solutions are sustained? 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	

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F 312	Continued From page 2 The facility policy Care of Fingernails/Toenails, dated 2/11, indicated the purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. General guidelines 1. Nail care includes daily cleaning and regular trimming. Documentation 6. If the resident refused treatment, the reason(s) why and the intervention taken. Reporting 1. Notify the supervisor if the resident refuses care.	F 312	of correction is integrated into the quality assurance system. The update to the tasks and automatic charting triggers every shift in Point of Care to prompt staff to check fingernails during cares will assist in the sustainability. Staff education will be done on Plan of Correction initiated, expectations of nail care, and documentation changes prior to date of correction. A comprehensive audit of all resident fingernails will be completed prior to date of correction by Director of Nursing Services or designee. Random audits will then be conducted by Director of Nursing Services or designee on random residents to check nail length and cleanliness. Audits will continue weekly for 4 weeks on random resident appearance and condition of fingernails and then monthly for 4 months on random residents to ensure continued compliance. Findings and progress will be reviewed with the Quality Assurance/Quality Improvement Committee. Who is responsible for this plan of correction? The Director of Nursing or designee will be responsible for compliance. Date of Correction:	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		6/26/16

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F 323	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to furnish a call light located in the bathroom for resident access to prevent falls for 1 of 1 resident (R82) who had a history of falls and the call light was an assessed device to prevent more falls. Findings include: R82 had been observed on 5/16/16 at 6:22 p.m., R82 was seated in a chair in her room by her window. She was seated next to the doorway of the bathroom. The light was on in the bathroom. In the bathroom there was no call light device to be found. The bathroom was not a shared bathroom. The resident was observed to have a dark bruise on the top of her right hand that was roughly the size of an orange. She stated that she had fallen out of bed not too long ago. Upon discovery that there was no call light in the bathroom, this surveyor notified nursing assistant (NA)-C that there was no call light in the bathroom. When asked why, NA-C did not know but stated there should be a call light in the bathroom. NA-C then notified the director of nursing (DON) of the situation. At that time, the DON then called the on-call maintenance person who came back to the facility and installed a functioning call light in R82's bathroom. When interviewed on 5/17/16 at 11:13 a.m., maintenance (M)-B stated that he runs a call light device report monthly to test for low battery	F 323	PLAN OF CORRECTION 5/25/2016 F 323 ¿483.25(h) Facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? For resident (R82), a functioning call light was placed in resident bathroom on 5/16/16. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents in the facility who are at risk for falls are at risk. Routine room checks upon admission and discharge of residents will be completed to ensure call lights are present in all resident rooms and bathrooms. Rooms will also be checked for call light presence during assessment of incidents/accidents. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Facility wide call light placement check/audit was completed to ensure functioning call lights are available in all rooms and in all bathrooms (Completed	

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F 323	Continued From page 4 levels. He stated that on 5/16/16 he ran a report and noticed that the battery in the call light in R82's bathroom was low. He stated that he replaced the battery. But had not returned the unit back to the holder located in R82's bathroom. R82's admission record, dated 5/3/16, indicated that the resident had diagnoses of: dementia, cataract, age-related macular degeneration (an incurable eye disease leading to vision loss), myopia (nearsightedness), blindness in one eye; low vision in other eye; frequency of micturition (urination). R82's temporary care plan, dated 5/3/16, indicated that the resident was at risk for falls related to weakness, cognitive impairment, cardiac disease, arthritis and a prior history of falls. To achieve the goal of no falls, the facility recommended that the resident was to keep a call light within reach while in her room and to remind her on how and when to use it. R82's comprehensive fall assessment, dated 5/3/16, stated that the resident had fallen one to two times within the past six months; she had taken medications which predisposed her to falls; she sometimes had memory and recall ability; she used an assistive device; and had a decrease in muscle coordination. R82's care area assessment (CAA), not dated, indicated that the resident was at a high risk for falls related to impaired vision, dementia, impaired mobility and an unsteady gait. Care plan considerations identified in the summary indicated a need to: avoid complications, maintain current level of functioning and to minimize risks.	F 323	5/25/16). Routine room checks upon admission and discharge of residents will be completed to ensure call lights are present in all resident rooms and bathrooms. Staff education will be provided prior to date of correction related to use of wireless call system, its portability, and the importance of checking each shift if residents have a call light in each location (bedroom and bathroom). How the facility plans to monitor its performance to make sure that solutions are sustained? 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. Facility wide call light placement audit was completed on 5/25/16 to ensure all resident rooms and bathrooms have functioning call light. Staff education will be provided prior to date of correction related to use of wireless call light system and importance of checking each shift if residents have a call light in each location (bedroom and bathroom). Call light placement/presence will be evaluated during routine facility incident/accident investigations. Random audits will be completed weekly x 4 weeks to ensure call lights are in place in each resident location (bedroom and bathroom). Audits will continue at least monthly x 4 months to ensure continued compliance. Findings and progress will be reviewed with the Quality Assurance/Quality Improvement Committee.	

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F 323	Continued From page 5 R82's Kardex (a guide for nursing assistants on how to care for a particular resident), indicated that the resident was at risk for falls. It stated that she was a stand-by assist with walking and transferring. R82's progress notes, reviewed from 5/3/16 through 5/18/16, indicated that the resident had fallen in the facility on 5/4/16. At 1:28 p.m., it stated, "This nurse (sic) called to residents room at 0755 [7:55 a.m.] after housekeeper observed resident ambulating in hallway with wounds on her left bicep. Resident informed housekeeper that she had fallen while trying to roll over in her bed. This nurse arrived and noted resident to be using the bathroom with her pajamas saturated with blood." The resident suffered skin tears from this fall. When interviewed on 5/17/16 at 11:22 a.m., nursing assistant (NA)-D stated that R82 had used her call light in the past. NA-D stated that the resident had used the call light during her previous shifts. When interviewed on 5/17/16 at 2:22 p.m., R82 stated that if she had to use the call light she would "press the red button." When interviewed on 5/18/16 at 8:24 a.m., the occupational therapist (OT) stated that when the resident was at home she had multiple falls and the family was concerned. They were concerned that R82 was not performing self cares thoroughly. The OT stated that the resident should have a call light in her bathroom. The OT stated that R82 was able to do every activity except standing (from a sitting position).	F 323	Who is responsible for this plan of correction? The Director of Nursing or designee will be responsible for compliance. Date of Correction: 6/26/16	

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F 323	Continued From page 6 When interviewed on 5/18/16 at 12:07 p.m., the physical therapist (PT) stated that R82 should have a call light in the bathroom. When interviewed on 5/18/16 at 1:25 p.m., the director of nursing (DON) stated that R82 should have had a functioning call light in the bathroom. Review of the facility policy titled, "Answering the Call Light" (February, 2011), it stated that the call light should be plugged in at all times. Review of the facility policy titled, "Assessing Falls and Their Causes" (March, 2011), it stated that relevant environmental issues should be addressed promptly.	F 323		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. 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. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425		6/26/16

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F 425	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to administer eye medication as ordered for 1 of 6 residents (R23) reviewed for medication administration. Findings include: R23's admission record, indicated the resident was admitted on 8/6/15. R23's order summary report, dated 8/6/15, indicated that the resident was prescribed Muro 128 Solution 5%: instill one drop in both eyes four times a day for comfort and a decrease in corneal (front part of the eyeball) swelling. R23's medication administration record (MAR), reviewed from 5/1/16 through 5/16/16, indicated that the resident was receiving the prescribes eyedrop medication as ordered. During an observation of a medication administration on 5/17/16 at 3:25 p.m., licensed practical nurse (LPN)-A was preparing to administer eyedrop medication to R23. The label on the bottle of medication read: Muro 128 2% opth (opthalmic) sol (solution) instill one drop into the affected eye QID (four times daily). When asked which affected eye the eyedrop was to be administered LPN-A had to look it up in the computer. The order for eyedrop medication in R23's medical record read: Muro 128 5% soln (solution) instill one drop in both eyes QID. Which was not the same as what LPN-A was going	F 425	PLAN OF CORRECTION 5/29/16 F 425 ¿483.60(a)(b): Procedures; Service Consultation The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in 483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) The 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. (b) The facility must employ or obtain the services of a licensed pharmacist who □ Provides consultation on all aspects of the provision of pharmacy services in the facility. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Medication orders prior to discharge to hospital and medication orders upon return from hospital for R23 were reviewed on 5/17/16. R23 was discharged to hospital with orders for Muro 5% eye drops and returned from hospital with orders for Muro 2% eye drops. Muro 2% eye drops were noted on	

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F 425	Continued From page 8 instill. Upon inspection of the medication cart where LPN-A had retrieved the incorrect eyedrop medication, there were no other medication bottles with the correct label. This had been the only bottle in R23's cubby in the medication cart. After bringing this to the attention of LPN-A she consulted with registered nurse (RN)-A and came back with a new bottle of eyedrop medication with the label that matched the order in R23's medical record. This new bottle had come from the medication room which LPN-A had placed an open-date of 5/17/16 which indicated the bottle had just been opened that date. LPN-A proceeded to administer the medication to R23 in his room. When interviewed on 5/17/16 at 3:46 p.m., registered nurse (RN)-A stated that R23 had probably been receiving the wrong medication since coming back from the hospital on 1/29/16. RN-A stated that when R23 was in the hospital and discharged back to the facility on 1/29/16, R23 had come back with orders for Muro 128 2% drops: 1 drop ophthalmic (in the eyes) four times a day. RN-A explained that the order was not identified as a new order in the discharge summary; it was identified as a continuing order and so the discrepancy in medications had never been reconciled when the resident returned from the hospital. When interviewed on 5/18/16 at 1:20 p.m., the director of nursing (DON) stated that the discrepancy occurred when the resident returned from the hospital and the hospital did not indicate that there was a new order change. The DON stated that the nursing staff should have checked to make sure all medications are the same as those in the electronic record to make sure they	F 425	readmission orders as Continued Medication. On 5/17/16, order was obtained from Primary Care Provider to continue with previous order of Muro 5% eye drops. Bottle of 2% eye drops was discarded on 5/17/16 and 5% drops were placed in medication cart for administration. Resident was monitored for potential adverse effects and none were noted. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Other residents at risk are residents who are discharged from the facility to the hospital for an acute issue and then readmitted to the facility. Upon readmission, licensed nursing staff will check all orders that are returning with the resident. If a medication is noted to be a Continued Medication and the order is different from what the resident was discharged to the hospital with, an order clarification will be obtained by licensed nursing staff from either the Primary Care Provider (PCP), or discharging hospital provider. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? All re-admission medication orders will be checked by 2 licensed nursing staff and compared to previous MAR to ensure accuracy and that all changed medications are reflected accurately in the MAR. Upon a resident□s readmission to facility, if medications that are noted to be continued medications have	

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F 425	Continued From page 9 are accurate. When interviewed on 5/18/16 at 1:49 p.m., the consultant pharmacist stated that the physician's orders need to match the medication being administered. Review of the facility policy titled, "Medication Orders" (February, 2014), it stated when medication orders were recorded, specify the correct type, route, dosage, frequency and strength of the medication ordered. Review of the facility policy titled, "Physician Medication Orders" (April 2014), it stated that medications should be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state. It stated that no drugs or biologicals should be administered except upon the order of a person lawfully authorized to prescribe for and treat human illnesses. Orders for medications must include: name and strength of the drug; quantity or specific duration of therapy; dosage and frequency of administration; route of administration; indication; stop date if indicated. Review of the facility policy titled, "Administering Medications" (February 2014), it stated that medications must be administered in accordance with the orders, including any required time frame. It stated that the individual administering the medication must check the label three times to verify the right resident, right medication, right dosage, right time and right method of administration before giving the medication.	F 425	discrepancies from orders in place prior to discharge to hospital, clarification orders will be obtained from either the residents PCP, or the discharging hospital provider. When medications arrive from pharmacy, medications will be checked against the MAR prior to being placed in the medication cart. If a discrepancy is noted, the most recent order will be reviewed by the licensed nurse and the pharmacy and/or consulting pharmacist will be notified and correct medication will be requested from the pharmacy.How the facility plans to monitor its performance to make sure that solutions are sustained? 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. Staff education will be completed prior to date of correction to provide further education to staff who administer medications on the 7 rights of medication administration (right client, medication, dose, route, time, reason, and documentation) and checking the medication against the MAR prior to placing it in the medication cart. Education will be completed to licensed nursing staff prior to date of completion on procedure for reconciling orders upon a resident□s readmission to the facility. Director of Nursing Services or Designee will complete random audits of medication orders and medications present in the medication cart will be completed on at least 1 resident with new or potentially	

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F 425	Continued From page 10	F 425	changed medication orders weekly x 4 weeks, and monthly x 4 months to ensure continued compliance. Findings and progress will be reviewed with the Quality Assurance/Quality Improvement Committee. Who is responsible for this plan of correction? The Director of Nursing or designee will be responsible for compliance. Date of Correction: 6/26/16	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. The facility must provide separately locked,	F 431		6/26/16

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	245442	A. BUILDING _____ B. WING _____	05/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	800 MEMORIAL DRIVE SPRING VALLEY, MN 55975

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F 431	Continued From page 11 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 maintain a proper storage temperature for 1 of 1 medication refrigerators in the facility which stored medication that needs to be kept at optimal temperature to maintain optimal potency. Findings include: During an observation of the medication storage room on 5/18/16 at 11:37 a.m. with licensed practical nurse (LPN)- B, it was observed that the refrigerator temperature read 48 degrees Fahrenheit. On one of the trays in the fridge were insulin pens. In the bottom shelf of the refrigerator were several unopened vials of tuberculin testing solution. There was one opened vial that was dated 4/25/16 when it was opened. When asked if the facility monitored the temperature of the refrigerator, LPN-A stated that the facility was supposed to check the temperature on a daily basis. LPN-A then provided a log book that staff were record temperatures of the refrigerator. The logs latest entry was on 10/14/15 when the temperature of the refrigerator registered 36 degrees. There were only two other entries for	F 431	PLAN OF CORRECTION 5/25/16 F 431 ¿483.60(e): Storage of Drugs and Biologicals The facility must ensure that all drugs and biologicals are stored in locked compartments under proper temperature controls. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Medications requiring refrigeration will be disposed of and new medications will be ordered from pharmacy. Residents and staff who received medications that require refrigeration in the time frame when temperature was noted to be out of recommended manufacturer control range and were still in the facility will be repeated to ensure medications administered were effective and adequately temperature controlled per manufacturer recommendations (36-46 degrees F). Completed 5/25/16 How will you identify other residents	

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F 431	Continued From page 12 the month of October 2015 and none since. LPN-B stated that she was going to notify maintenance that the fridge was 48 degrees. She stated that she was also going to notify the director of nursing. When interviewed on 5/18/16 at 11:58 a.m., registered nurse (RN)-A stated that 48 degrees was too warm for the refrigerator to store medications. She stated that the staff should be checking the fridge on a daily basis. She stated that the temperature should read between 35 and 40 degrees Fahrenheit. The facility provided a list of residents and staff who had received a dose of the tuberculin testing solution from the opened vial in the fridge. The facilty also provided a list of residents who had medications stored in the fridge. When interviewed on 5/18/16 at 1:22 p.m., the director of nursing stated that the refrigerator temperatures should be checked daily. She stated that if the fridge temperatures are too warm then maintenance should be notified to adjust the temperature of the fridge. The DON stated that she checked the website of the Centers for Disease Control (CDC) as well as the website of the Minnesota Department of Health (MDH) which she stated both sites recommended refrigerator temperatures should be maintained between 35 and 46 degrees Fahrenheit. She stated that if the temperatures of the refrigerator were ever questions, she would either destroy the medications and reorder or check with each distributor of the medication for their recommendations. When interviewed on 5/18/16 at 1:32 p.m., the	F 431	having the potential to be affected by the same deficient practice and what corrective action will be taken? Facility will routinely monitor refrigerator temperatures to ensure all medications are stored under manufacturer recommendations. Other residents potentially affected by practice are residents who would potentially receive medication administration of medications requiring refrigeration if the refrigerator temperature falls outside of the acceptable temperature ranges. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Policy on medication storage was reviewed and updated to include the acceptable temperature parameters for medication storage. Refrigerator temperature logs were updated to reflect spots for each shift to check the refrigerator temperatures. Refrigerator temperature logs will be kept up to date and temperatures will be checked at least once per day. How the facility plans to monitor its performance to make sure that solutions are sustained? 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. Staff education will be completed prior to date of correction to ensure all staff are aware of the updates to the Medication Storage policy, acceptable parameters for refrigeration of	

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F 431	Continued From page 13 consultant pharmacist stated that the staff should be checking the temperature of the fridge more frequently then the log they provided. He stated that if medications are stored above 46 degrees for a fair amount of time they do degrade and become less effective. Review of the package insert for the Aplisol Tuberculin testing solution, it stated that the solution should be stored between 36 and 46 degrees Fahrenheit. Review of the U.S. Food and Drug Administration (FDA) website on 5/19/16 at 2:45 p.m., it recommended that insulin be stored in a refrigerator between 36 and 46 degrees Fahrenheit. It stated that unopened and stored in this manner, insulin would maintain its potency. Review of the facility policy titled, "Storage of Medications" (April 2014), it stated that the facility should store all drugs and biologicals in a safe, secure, and orderly manner. The facility should not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs should be returned to the dispensing pharmacy or destroyed. No mention of a temperature range was noted.	F 431	medications, plan for monitoring refrigerator temperatures (at least daily), and what to do if temperatures are out of recommended range (re-order medications, defrost refrigerator, increase or decrease temperature of refrigerator). Temperature logs were updated to reflect acceptable temperature ranges. Director of Nursing Services or Designee will complete random audits of refrigerator temperatures and temperature logs weekly x 4 weeks and at least monthly for 4 months to ensure continued compliance. Findings and progress will be reviewed with the Quality Assurance/Quality Improvement Committee. Who is responsible for this plan of correction? The Director of Nursing or designee will be responsible for compliance. Date of Correction: 6/26/16	
F 441 SS=D	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	F 441		6/27/16

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F 441	Continued From page 14 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 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 observation, interview and record review, the facility failed to ensure infection control standards were followed for 1 of 1 resident (R53) observed for blood glucose monitoring and glove use. Findings include:	F 441	PLAN OF CORRECTION 5/25/16 F 441 ¿483.65(b) Preventing Spread of Infection The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the	

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F 441	Continued From page 15 R53 had been observed to received blood glucose testing on 5/16/16 at 3:52 p.m. by trained medication aide (TMA)-A. TMA-A brought the blood glucose testing supplies with her to R53's room. TMA-A did not apply gloves. TMA-A used a lancet on R53's finger to draw blood and place a drop of R53's blood on the testing strip. TMA-A removed the testing strip from the glucometer while in R53's room. TMA-A returned to the medication cart at the end of the hall near the front desk where she deposited the lancet and testing strip into the sharps container affixed to the medication cart. Without wearing gloves TMA-A wiped the glucometer with a Super Sani Cloth, leaving the glucometer wrapped in the Super Sani Cloth. TMA-A then touched her keyboard, mouse, and the medication cart in several locations. TMA-A removed the Super Sani Cloth after one minute placing the glucometer in a drawer on the medication cart, typed on the keyboard, and stepped away from the medication cart to talk with a resident's family member. Upon returning to the medication cart TMA-A used an alcohol based hand rub on her hands. On 5/26/16 at 3:59 p.m. TMA-A stated, "I normally have gloves with me, I just forgot them." On 5/16/16 at 4:06 p.m. the director of nursing was asked about the process of taking blood sugar readings and she stated, "They [staff] wash their hands, put on gloves, check the blood sugar, remove their gloves, and clean it with the purple wipes." Cleansing and Disinfecting Blood Glucose Meters dated June 2014 reads; "Gloves must be used for	F 441	development and transmission of disease and infection. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Nursing personnel that were observed in deficient practice during blood glucose check was immediately counseled by Director of Nursing Services on appropriate sanitary standards when checking blood glucose (Completed 5/16/16). Director of Nursing Services observed affected resident (R53) for any signs of illness that could have resulted from unsanitary practice. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents who are admitted to facility and require blood glucose checks could potentially be affected. Currently, 11 residents reside in facility who receive scheduled blood glucose checks. Director of Nursing Services or Designee will re-educate all nursing staff that check blood glucose levels on appropriate and sanitary procedures to be followed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Facility policy regarding blood glucose checks was reviewed 5/25/16. Director of Nursing Services or Designee will provide education to all nursing staff on expectations of checking blood glucose in a sanitary manner prior to date of correction in addition to immediate correction that was completed on 5/16/16.	

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F 441	Continued From page 16 finger sticks during glucose monitoring, administration of Insulin, and any other procedure that involves potential exposure to blood or body fluids...Apply gloves to obtain droplet of blood on the glucose test strip...Remove gloves and wash hands. Apply new gloves. Thoroughly cleanse all soil from the glucometer during disinfection. Using gloves as indicated, cleanse glucometer with Sani-Cloth HB Germicidal disposable wipes. Glucometer must stay WET for 2 minutes. This may be accomplished by continuous wiping of the glucometer with the wipe OR wipe the glucometer then wrap the glucometer in the wipe and let sit for at least 2 minutes. Allow the glucometer to dry prior to next use. Remove gloves and either wash hands as directed or use an alcohol based hand rub."	F 441	How the facility plans to monitor its performance to make sure that solutions are sustained? 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. Director of Nursing Services or Designee will present education to nursing staff that perform blood glucose checks prior to date of correction. Policy for blood glucose monitoring will be reviewed with staff to review appropriate procedure. Education on use of standard precautions with all tasks that involve potential exposure and hand hygiene will also be presented. Director of Nursing Services or Designee will perform blood glucose proficiency audits weekly for 4 weeks and monthly for 4 months. Findings and progress will be reviewed with the Quality Assurance/Quality Improvement Committee. Who is responsible for this plan of correction? The Director of Nursing or designee will be responsible for compliance. Date of Correction: 6/27/16	
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.	F 463		6/27/16

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F 463	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to have access to a functioning call light in the bathroom for 1 of 30 residents (R82) reviewed for functioning call lights. Findings include: R82's bathroom was checked for a functional call light on 5/16/16 at 6:22 p.m., and on entry to the room there was no call device present. Upon discovery that there was no call light in the bathroom, this surveyor notified nursing assistant (NA)-C that there was no call light in the bathroom. When asked why, NA-C did not know but stated there should be a call light in the bathroom. NA-C then notified the director of nursing (DON) of the situation. At that time, the DON then called on-call maintenance who came back to the facility and installed a functioning call light in R82's bathroom. When interviewed on 5/17/16 at 11:13 a.m., maintenance (M)-B stated that he runs a call light report monthly which identifies if there are any units with low battery levels. He stated that on 5/16/16 he ran the report and noticed that the battery in the call light in R82's bathroom was low. He stated that he replaced the battery and forgot to return the unit to the bathroom. When interviewed on 5/18/16 at 1:25 p.m., the director of nursing (DON) stated that R82 should have had a functioning call light in the bathroom.	F 463	PLAN OF CORRECTION 5/25/2016 F 463 ¿483.70(f) Nurses station must be equipped to receive resident calls through a communication system from (1) Resident rooms; and (2) Toilet and bathing facilities. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? For resident (R82), a call light was placed in resident bathroom on 5/16/16. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents in the facility are at risk; call lights are wireless and portable. Routine room checks upon admission and discharge of residents will be completed to ensure call lights are present in all resident rooms and bathrooms. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Facility wide call light placement check/audit was completed to ensure call lights are available in all rooms and in all bathrooms (Completed 5/25/16). Routine room checks upon admission and discharge of residents will be completed to ensure call lights are present in all resident rooms and bathrooms. Staff education will be provided prior to date of	

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F 463	Continued From page 18 Review of the facility policy titled, "Answering the Call Light" (February, 2011), it stated that the call light should be plugged in at all times.	F 463	correction related to use of wireless call system, its portability, and the importance of checking each shift if residents have a call light in each location (bedroom and bathroom). How the facility plans to monitor its performance to make sure that solutions are sustained? 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. Facility wide call light placement audit was completed on 5/25/16 to ensure all resident rooms and bathrooms have functioning call light. Staff education will be provided prior to date of correction related to use of wireless call light system and importance of checking each shift if residents have a call light in each location (bedroom and bathroom). Random audits will be completed weekly x 4 weeks to ensure call lights are in place in each resident location (bedroom and bathroom). Audits will continue at least monthly x 4 months to ensure continued compliance. Findings and progress will be reviewed with the Quality Assurance/Quality Improvement Committee. Who is responsible for this plan of correction? The Director of Nursing or designee will be responsible for compliance. Date of Correction: 6/27/2016	
F 465	483.70(h)	F 465		6/27/16

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F 465 SS=C	Continued From page 19 SAFE/FUNCTIONAL/SANITARY/COMFORTABL E ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the exhaust vents located in resident bathrooms were cleaned to maintain a sanitary bathroom environment in 24 of 31 bathrooms (401, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 415, 501, 502, 503, 504, 505, 507, 509, 514, 516, 620, 622, 623, 624, 626, and 627) used by residents who resided in adjoining bedroom. Findings include: Upon entrance to the facility on 5/16/16 at 1:00 p.m. resident bathrooms in rooms 409, 411, 412, 413, 415, and 622 were observed to have visible heavy dust present on the vent grille cover. Upon further investigation on 5/18/16 at 8:55 a.m. the following bathroom fans had heavy dust present on vent grille covers: 401, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 415, 501, 502, 503, 504, 505, 507, 509, 514, 516, 620, 622, 623, 624, 626, and 627 which had bee visible from the doorway of the bathroom. On 5/18/16 at 8:57 a.m. the maintenance director observed the exhaust vent in the bathroom in room 501 with surveyor. The maintenance director pointed at the exhaust vent and stated, "That's on the exhaust end, they [exhaust vents]	F 465	PLAN OF CORRECTION 5/25/2016 F 465 ¿483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFO RTAB LE ENVIRONMENT. The facility must provide a safe, functional sanitary, and comfortable environment for residents, staff and the public. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The EVS standard cleaning schedule was enhanced to include the checking of need for cleaning vents in each resident room. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All vents within the nursing home will be included in the EVS standard cleaning schedule for checking and cleaning as necessary. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The EVS standard cleaning schedule was enhanced to include the checking of the need for cleaning vents in each room.	

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F 465	Continued From page 20 are on the radar, just haven't done it yet. I will talk to my leads about it. It's obvious it's not being done. We have a deep clean schedule but the vents are not on the list." The maintenance director verified the vent grille cover was covered in a thick layer of dust adding he "guessed it should be completed annually." Environmental Services Daily Standard Cleaning Guide was provided for the west wing, TCU, and south wing; which did not include a cleaning schedule for the bathroom vents.	F 465	How the facility plans to monitor its performance to make sure that solutions are sustained? 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. EVS director will periodically review the cleaning schedules and perform random spot checks to ensure compliance with the enhanced EVS standard cleaning schedule. The results of these spot checks will be incorporated into the EVS internal quality assurance program. Who is responsible for this plan of correction? The Director Environmental Services designee will be responsible for compliance. Date of Correction: 6/27/2016	

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	245442	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/18/2016**

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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 FORM 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 REGULATION 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 on May 18,2016. At the time of this survey Spring Valley Care Center 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 St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/31/2016

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
	245442	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/18/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	**800 MEMORIAL DRIVE** **SPRING VALLEY, MN 55975**

(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 By email to: 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 Spring Valley Care Center is a 1-story building with a partial basement. The building was constructed in 1962 and was determined to be of Type II(111) construction. In 2014 the facility added a new Wing to the Northside of the building. The building is surveyed as 2 building for different years of construction. The building is fully fire sprinkler protected. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 50 beds and had a census of 46 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 054 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved,	K 054		6/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245442	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/18/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	**800 MEMORIAL DRIVE** **SPRING VALLEY, MN 55975**

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K 054	Continued From page 2 maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on staff interview and review of available documentation, the facility has not been conducting sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA 72 (99), Sec. 7-3.2.1. This deficient practice could affect all 46 residents. Findings include: On facility tour between 9:30AM and 12:30 PM on 5/18/2016, a review of the facility's Records of system smoke detector sensitivity testing performed show 5 smoke detectors did not pass and needed replacement. A record was provided laster showing the detectors were replaced. This deficient practice was verified by the Maintenance Supervisor.	K 054	PLAN OF CORRECTION 5/25/2016 K054 All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications 9.6.1.3 What corrective action will be accomplished: The EVS director will continue to follow the process of inspections and replacements of smoke detectors as required. The sensitivity testing done in 2015 resulted in replacement of several smoke alarms in a timely manner. The EVS Director will follow the every other year sensitivity testing by outside agency and replace any identified smoke detectors as was done this past year. What measure will be put in place to ensure compliance: The sensitivity testing every other year will be the monitor to ensure compliance. How will the facility monitor: The review of the sensitivity testing results by the EVS Director with the agency providing the testing will provide a monitoring to ensure compliance. Who is responsible for this plan of correction: The EVS Director or designee will be responsible for compliance. Date completed 6.26.16	
K 074	NFPA 101 LIFE SAFETY CODE STANDARD	K 074		6/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245442	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/18/2016**

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K 074 SS=F	Continued From page 3 Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations are flame resistant in accordance with NFPA 701 except for shower curtains. Sprinklers in areas where cubical curtains are installed shall be in accordance with NFPA 13 to avoid obstruction of the sprinkler. 10.3.1, 18.3.5.5, 19.3.5.5, 18.7.5.1, 19.7.5.1, NFPA 13 o Newly introduced upholstered furniture shall meet the char length and heat release criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3, 18.7.5.2, 19.7.5.2. o Newly introduced mattresses shall meet the char length and heat release criteria specified when tested in accordance with the method cited in 10.3.2 (3) and 10.3.4. 18.7.5.3, 19.7.5.3 o Newly introduced upholstered furniture and mattresses means purchased since March, 2003. This STANDARD is not met as evidenced by: Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations are flame resistant in accordance with NFPA 701 except for shower curtains. Sprinklers in areas where cubical curtains are installed shall be in accordance with NFPA 13 to avoid obstruction of the sprinkler. 10.3.1, 18.3.5.5, 19.3.5.5, 18.7.5.1, 19.7.5.1, NFPA 13 o Newly introduced upholstered furniture shall meet the char length and heat release criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3, 18.7.5.2, 19.7.5.2.	K 074	PLAN OF CORRECTION 5/25/2016 K074 draperies, curtains, including cubicle curtains and other loosely hanging fabrics and films serving as furnishings or decorations are flame resisitant in accordance with NFPA701 except for shower curtains. Sprinklers in areas where cubical curtains are installed shall be in accordance with NFPA 13 to avoid obstruction of the sprinkler. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The EVS director will have	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245442	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/18/2016**

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245442	A. BUILDING **02 - SPRING VALLEY CARE CENTER** B. WING _____	**05/18/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	**800 MEMORIAL DRIVE SPRING VALLEY, MN 55975**

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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 FORM 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 REGULATION 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 on May 18, 2016. At the time of this survey Spring Valley Care Center 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 St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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 054 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved,	K 054		6/26/16

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K 074	NFPA 101 LIFE SAFETY CODE STANDARD	K 074		6/30/16

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