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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: B7BU

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00731

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245378**
2.STATE VENDOR OR MEDICAID NO.
(L2) **425340000**

3. NAME AND ADDRESS OF FACILITY
(L3) **VALLEY VIEW MANOR**
(L4) **200 EAST NINTH AVENUE**
(L5) **LAMBERTON, MN** (L6) **56152**

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 February 26, 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)
09/30

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

12.Total Facility Beds **55** (L18)

13.Total Certified Beds **55** (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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	55			
(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):

Post Certification Revisit by review of the facility's plan of correction to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. The facility is certified for 55 skilled nursing facility beds effective February 14, 2014.

17. SURVEYOR SIGNATURE — Date :
Kathryn Serie, Unit Supervisor 02/26/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Colleen Leach, Program Specialist 04/24/2014 (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
03/20/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5378 April 24, 2014

Ms. Dawn Giese, Administrator
Valley View Manor
200 East Ninth Avenue
Lamberton, Minnesota 56152

Dear Ms. Giese:

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 February 14, 2014 the above facility is certified for:

55 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 55 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,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit
Licensing and Certification Program

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

February 26, 2014

Ms. Dawn Giese, Administrator Administrator
Valley View Manor
200 East Ninth Avenue
Lamberton, MN 56152

RE: Project Number S5378027

Dear Ms. Giese:

On January 21, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 9, 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 February 26, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on February 24, 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 January 9, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 14, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 9, 2014, effective February 14, 2014 and therefore remedies outlined in our letter to you dated January 21, 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,

Kathryn Serie

Kathy Serie, Unit Supervisor
Licensing and Certification Program
Telephone: (507) 537-7158 Fax: (507) 344-2723

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

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
245378	A. Building B. Wing	2/26/2014

Name of Facility	Street Address, City, State, Zip Code
VALLEY VIEW MANOR	200 EAST NINTH AVENUE LAMBERTON, MN 56152

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 F0278 Reg. # 483.20(g) - (j) LSC	02/14/2014	ID Prefix F0441 Reg. # 483.65 LSC	02/14/2014	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** KS/cbl	**Date:** 02/26/2014	**Signature of Surveyor:** 03048	**Date:** 04/24/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 1/9/2014		**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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245378	01 - MAIN BUILDING 01	2/24/2014

Name of Facility	Street Address, City, State, Zip Code
VALLEY VIEW MANOR	200 EAST NINTH AVENUE LAMBERTON, MN 56152

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 Reg. # NFPA 101 LSC K0051	02/14/2014	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		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/cbl	Date: 02/24/2014	Signature of Surveyor: 22373	Date: 04/24/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 1/7/2014		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: B7BU

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00731

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245378**
2.STATE VENDOR OR MEDICAID NO.
(L2) **425340000**

3. NAME AND ADDRESS OF FACILITY
(L3) **VALLEY VIEW MANOR**
(L4) **200 EAST NINTH AVENUE**
(L5) **LAMBERTON, MN** (L6) **56152**

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 **01/09/2014** (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)
09/30

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

12.Total Facility Beds **55** (L18)

13.Total Certified Beds **55** (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
	55			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Wendy Buckholz, HFE NE II 02/07/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 02/28/2014 (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 03/20/2014 CO. B7BU

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN 24-5378

At the time of the Standard survey on January 9, 2014, the facility was not in substantial compliance with Federal Certification Regulations. This survey found the most serious deficiencies in the facility to widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), Post Certification Revisit to follow. Please refer to the CMS 2567 along with the facility's plan of correction.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 8309

January 21, 2014

Ms. Dawn Giese, Administrator
Valley View Manor
200 East Ninth Avenue
Lamberton, Minnesota 56152

RE: Project Number S5378027

Dear Ms. Giese:

On January 9, 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:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - 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:

Kathryn Serie, Unit Supervisor
Minnesota Department of Health
1400 E. Lyon Street
Marshall, MN 56258
Office: (507) 537-7158
Fax: (507) 537-7194

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 February 18, 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 February 18, 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 April 9, 2014 (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 July 9, 2014 (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 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING _____ B. WING _____	01/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 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 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each	F 278	See attached approved ENT 2/7/14	

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

[signature] | Executive Director | 1/31/14

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
	245378	A. BUILDING _____ B. WING _____	01/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 278	Continued From page 1 assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to accurately code the Minimum Data Set (MDS) assessment for 1 of 3 residents (R14) reviewed who had experienced a significant weight loss. Findings include: R14's record was reviewed and the admission MDS dated 9/11/13, indicated R14's diagnoses included: hip fracture, diabetes mellitus, hemiparesis/hemiplegia and congestive heart failure. R14's admission nutritional assessment dated 9/13/13 indicated a mechanically altered diet was provided, subsequent to the dietary progress note dated 9/4/13 which indicated R14 had a swallowing disorder. The admission MDS identified R14's weight as 208# (pounds). No weight loss or weight gain of 5% or more in the last month was identified on the assessment. The 30 day PPS (medicare) MDS dated 10/2/13, identified R14's weight as 191#. This was a loss of 17#'s in 22 days or an approximate 8% weight loss. However, no weight loss was documented on this MDS. The 12/4/13 quarterly MDS assessment identified a weight of 188# (a 20# weight loss since admission). However, the MDS had documentation that included: "weight gain of 5% or more in the last month or gain of 10% or more in last 6 months	F 278		

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F 278	Continued From page 2 and not on a physician-prescribed weight gain regimen." Interview with the assistant director of nursing on 1/9/13 at 10 a.m. verified the noted MDS assessments had not accurately reflected R14's current status related to the weight loss that had been documented since admission.	F 278		
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 hands after each direct resident contact for which	F 441	See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 3 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 document review the facility failed to ensure staff implemented proper handwashing and glove removal for 1 of 2 residents (R8)reviewed who had wound dressing changes and failed to implement a system to track or trend staff illness and/or infections which had the potential to affect all 43 residents who reside in the facility. Findings include: On 1/8/14 at 10:35 a.m. licensed practical nurse (LPN)-A was observed to provide multiple dressing changes for R8. LPN-A gathered the dressing supplies and informed R8 that the suprapubic catheter site dressing would be changed. LPN-A donned clean gloves, removed the existing dressing surrounding the suprapubic catheter site and then deposited the dressing and soiled gloves into a garbage bag. After the removal of the soiled dressing, LPN-A donned clean gloves and cleansed the skin surrounding R8's catheter with a sterile saline wipe. After the completion of cleansing the site, LPN-A disposed of the saline wipe and removed her gloves. No handwashing was noted. Without the use of gloves, LPN-A then applied a new gauze	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 4 dressing to the suprapubic catheter site with her bare hands. It was noted that LPN-A did not cleanse her hands after removal of the gloves and/or after application of the clean dressing to R8's abdomen. After completion of the suprapubic catheter site care, LPN-A donned clean gloves, repositioned R8 onto his left side and then removed the existing dressing from the pressure ulcer on R8's right buttock. After removal of the dressing, LPN-A placed the dressing and the soiled gloves into the garbage bag and immediately donned clean gloves without proper handwashing. LPN-A then proceeded to cleanse the right buttock wound with sterile saline wipes and then applied the prescribed treatment and dressing to the wound. Upon completion of the treatment, LPN-A removed her gloves and tossed them in the garbage bag. Without cleansing her hands, LPN-A donned clean gloves and proceeded to remove the existing dressing from the pressure ulcer on R8's left buttock. LPN-A then placed the soiled dressing and her gloves into the garbage bag. Again, without cleansing her hands. LPN-A donned a clean set of gloves. LPN-A cleansed the left buttock wound with a sterile saline wipe and applied the prescribed treatment and dressing to the wound. After the clean dressings and treatment had been completed, the gloves were removed, tossed in the garbage bag and finally LPN-A cleansed her hands with an antibacterial cleanser. LPN-A then proceeded to donn clean gloves and removed the existing dressing from R8's left heel ulcer. LPN-A placed the dressing and the soiled	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 5 gloves into the garbage bag after removal of the soiled dressings. Without cleansing her hands, LPN-A donned clean gloves and cleansed R8's left heel with a sterile saline wipe and applied the prescribed treatment to the wound. LPN-A then removed her gloves and deposited them into the garbage bag. Without the use of gloves and with bare hands, LPN-A applied a hydrocellular dressing and abdominal (abd) pad to R8's left heel, wrapped the heel with gauze and secured with tape. LPN-A then proceeded to R8's lower left leg, donned clean gloves, and cleansed R8's lower left leg with baby shampoo and applied Kenalog cream to the leg per physician order. LPN-A changed gloves and removed the soiled dressing from R8's lower left calf. LPN-A deposited the dressing along with the gloves into the garbage bag. Without any handwashing, clean gloves were donned, the left calf wound was cleansed with sterile saline pads and the prescription treatment applied along with a dressing to the wound. LPN was not observed to cleanse her hands between any of the glove changes during the entire procedure. Again, LPN-A donned clean gloves and removed the dressing from R8's right heel. LPN -A placed the soiled dressing and the gloves into the garbage bag after removal of the dressing. Without any handwashing and/or hand hygiene, LPN-A donned clean gloves, cleansed R8's right heel with a sterile saline wipe and applied the prescribed treatment and dressing to the wound. LPN-A removed the gloves and deposited them into the garbage bag, cleaned the bandage scissors with an alcohol prep pad, and then positioned R8's legs on a pillow to elevate his	F 441		

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F 441	Continued From page 6 heels. LPN-A then placed R8's dressing supply bins into the closet and placed the garbage bag with old dressings/gloves, etc into a red hazardous waste bag. Finally, LPN-A washed her hands with soap and water and left the room with her treatment cart and waste bag. LPN-A took the hazardous waste bag directly to the soiled utility room and washed her hands with soap and water once disposing of the waste bag. When interviewed on 1/18/14 at 11:20 a.m., LPN-A confirmed that she had not cleansed her hands between each glove change and stated, "I usually do". LPN-A further stated that she tends to be in a hurry and not cleanse her hands between each dressing change, but will always change her gloves between wounds. When interviewed on 1/9/14 at 12:59 p.m., the assistant director of nursing (ADON) confirmed the expectation had been to perform proper hand hygiene with a change of gloves. When interviewed on 1/19/14 at 2:37 p.m., the director of nursing (DON) confirmed she would expect hand hygiene to be performed before donning and after removal of soiled gloves during a dressing change. The policy and procedure titled, "Hand Washing" dated 3/2010 indicated that hand washing is required before and after changing a dressing, and after removing gloves. Review of the facility's infection control surveillance information logs revealed no tracking or trending of staff illness and/or infection was evident . The impact of staff illness/infection had	F 441		

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F 441	Continued From page 7 not been tracked related to the impact on the facility's resident population. Interview with the director of nursing (DON) on 1/9/14 at 8:27 a.m. confirmed a mechanism had not been established within their infection control program to track and trend staff illness and/or infection. The DON stated that she logs all infections for the residents but doesn't track the employees infections.	F 441		

F 278 Assessment
Accuracy/Coordination/Certified

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to:

1. In the event of a coding error, we will do a significant correction to the prior MDS. Resident R14's MDS was corrected to accurately reflect his status at the time of the MDS.
2. All residents are reviewed for nutritional risk factors on admission, quarterly, annually, and upon significant change in condition.
3. Nutritional Status is reviewed for all residents at each care conference
4. All Resident weights will be discussed during IDT once monthly and/or weekly at IDT for residents identified as nutritionally at risk
5. Education provided for all staff having a role in completing the MDS.
6. The MDS Coordinator or designee will complete 1 audit per week for four weeks to ensure compliance in these areas.
7. The data collected will be reviewed/discussed at the quarterly QA meeting. At this time the QA committee will make the decision/recommendation regarding any follow-up studies.

The MDS Coordinator, DNS, and ED are responsible for the POC.

Completion date: February 14, 2014

F 441 Infection control, Prevent Spread, Linens

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to:

1. Proper Hand washing/Glove removal education provided to all employees per communication book 1-10-14 and at all staff meetings 2-5-14.
2. Process for Tracking/trending of staff illness and/or infection implemented 1-10-14
3. Infection Control policy updated to include process for tracking employee illness
4. Education to all employees regarding Infection Control policy updates
5. The DNS or designee will monitor for trends of employee illness comparing to resident illness trends
6. The DNS or designee will complete one audit (employee hand washing) per week for four weeks and then monthly to ensure compliance in these areas
7. The data collected will be reviewed/discussed at the quarterly QA meeting. At this time the QA committee will make the decision/recommendation regarding any follow-up studies.

The DNS is responsible for the POC

Completion date: February 14, 2014

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

F5378024

PRINTED: 01/21/2014
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
	245378	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 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 REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on January 7, 2014. At the time of this survey, Valley View Manor was found not to be 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) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. 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 55101-5145, or	K 000	POCok FB 2-3-14 RECEIVED FEB - 3 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 2-18-14
EXIT: 1-9-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dan Musil	Executive Directo	1-31-14

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.

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	245378	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/07/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR	**200 EAST NINTH AVENUE** **LAMBERTON, MN 56152**

(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. Valley View Manor was constructed as follows: The original building was constructed in 1972, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction; The 1st Addition was constructed in 1976, is one-story, has no basement, is fully fire sprinkler protected and is of Type V(111) construction; The 2nd Addition was constructed in 1989, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction; The 3rd Addition was constructed in 1999, is one-story, has a partial basement, is fully fire sprinkler protected and is of Type II(000) construction. The nursing home is separated from an assisted living facility by a 2-hour fire wall assembly, with an opening protective consisting of a labeled, 90-minute self-closing, positive latching fire door assembly. The facility has a fire alarm system with smoke detection at all smoke barrier doors. The 1999	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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VALLEY VIEW MANOR	**200 EAST NINTH AVENUE** **LAMBERTON, MN 56152**

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K 000	Continued From page 2 addition has a full corridor smoke detection system. The entire system is monitored for automatic fire department notification. The facility has a capacity of 55 beds and had a census of 43 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 051 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by:	K 051	See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 051	Continued From page 3 Based on observation and a staff interview, it could not be verified whether the facility's required automatic fire alarm system was installed and maintained in conformance with NFPA 101 (00) Chapter 19, Section 19.3.4. In a fire emergency, this deficient practice could adversely affect the safety of 55 of 55 residents, staff and visitors. FINDINGS INCLUDE: On 01/07/2014 at 2:05 PM, observation revealed a digital alarm communicator transmitter [DACT] module equipped with a single telephone line, and it could not be visually confirmed that the DACT was connected to two separate means of transmission, in accordance with NFPA 72 (1999) Chapter 5, Section 5-5.3.2.1.7.1. This finding was verified with the chief building engineer.	K 051		

K 051

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to:

1. Contact made with local telephone vendor to explore options to install another phone line on 1-17-14

2. Conversation with local telephone vendor to confirm number of current lines into facility and set up scheduled appointment 1-31-14

3. Local Phone vendor appointment set for 2-3-14 to identify phone lines and confirm that we have the DACT connected to a reliable second source

The ED and Maintenance Director are responsible for the POC.

Completion Date: February 14, 2014

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 8309

January 21, 2014

Ms. Dawn Giese, Administrator
Valley View Manor
200 East Ninth Avenue
Lamberton, Minnesota 56152

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5378027

Dear Ms. Giese:

The above facility was surveyed on January 6, 2014 through January 9, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules.

At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order.

This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health at:

Kathryn Serie, Unit Supervisor
Minnesota Department of Health
1400 E. Lyon Street
Marshall, MN 56258
Office: (507) 537-7158
Fax: (507) 537-7194

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: _____ B. WING _____	01/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On January 6, 7, 8 and 9th, 2014, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 1/31/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 Certification Program, 1400 E. Lyon Street, Marshall, Minnesota 56258.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control;	21390		

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21390	Continued From page 2 E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure staff implemented proper handwashing and glove removal for 1 of 2 residents (R8)reviewed who had wound dressing changes and failed to implement a system to track or trend staff illness and/or infections which had the potential to affect all 43 residents who reside in the facility. Findings include: On 1/8/14 at 10:35 a.m. licensed practical nurse (LPN)-A was observed to provide multiple dressing changes for R8. LPN-A gathered the dressing supplies and informed R8 that the suprapubic catheter site dressing would be changed. LPN-A donned clean gloves, removed the existing dressing surrounding the suprapubic catheter site and then deposited the dressing and soiled gloves into a garbage bag. After the	21390		

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21390	Continued From page 3	21390		

removal of the soiled dressing, LPN-A donned clean gloves and cleansed the skin surrounding R8's catheter with a sterile saline wipe. After the completion of cleansing the site, LPN-A disposed of the saline wipe and removed her gloves. No handwashing was noted. Without the use of gloves, LPN-A then applied a new gauze dressing to the suprapubic catheter site with her bare hands. It was noted that LPN-A did not cleanse her hands after removal of the gloves and/or after application of the clean dressing to R8's abdomen.

After completion of the suprapubic catheter site care, LPN-A donned clean gloves, repositioned R8 onto his left side and then removed the existing dressing from the pressure ulcer on R8's right buttock. After removal of the dressing, LPN-A placed the dressing and the soiled gloves into the garbage bag and immediately donned clean gloves without proper handwashing. LPN-A then proceeded to cleanse the right buttock wound with sterile saline wipes and then applied the prescribed treatment and dressing to the wound. Upon completion of the treatment, LPN-A removed her gloves and tossed them in the garbage bag.

Without cleansing her hands, LPN-A donned clean gloves and proceeded to remove the existing dressing from the pressure ulcer on R8's left buttock. LPN-A then placed the soiled dressing and her gloves into the garbage bag. Again, without cleansing her hands. LPN-A donned a clean set of gloves. LPN-A cleansed the left buttock wound with a sterile saline wipe and applied the prescribed treatment and dressing to the wound. After the clean dressings and treatment had been completed, the gloves were removed, tossed in the garbage bag and

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21390	Continued From page 4 finally LPN-A cleansed her hands with an antibacterial cleanser. LPN-A then proceeded to donn clean gloves and removed the existing dressing from R8's left heel ulcer. LPN-A placed the dressing and the soiled gloves into the garbage bag after removal of the soiled dressings. Without cleansing her hands, LPN-A donned clean gloves and cleansed R8's left heel with a sterile saline wipe and applied the prescribed treatment to the wound. LPN-A then removed her gloves and deposited them into the garbage bag. Without the use of gloves and with bare hands, LPN-A applied a hydrocellular dressing and abdominal (abd) pad to R8's left heel, wrapped the heel with gauze and secured with tape. LPN-A then proceeded to R8's lower left leg, donned clean gloves, and cleansed R8's lower left leg with baby shampoo and applied Kenalog cream to the leg per physician order. LPN-A changed gloves and removed the soiled dressing from R8's lower left calf. LPN-A deposited the dressing along with the gloves into the garbage bag. Without any handwashing, clean gloves were donned, the left calf wound was cleansed with sterile saline pads and the prescription treatment applied along with a dressing to the wound. LPN was not observed to cleanse her hands between any of the glove changes during the entire procedure. Again, LPN-A donned clean gloves and removed the dressing from R8's right heel. LPN -A placed the soiled dressing and the gloves into the garbage bag after removal of the dressing. Without any handwashing and/or hand hygiene, LPN-A donned clean gloves, cleansed R8's right heel with a sterile saline wipe and applied the	21390		

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21390	Continued From page 5	21390		

prescribed treatment and dressing to the wound. LPN-A removed the gloves and deposited them into the garbage bag, cleaned the bandage scissors with an alcohol prep pad, and then positioned R8's legs on a pillow to elevate his heels. LPN-A then placed R8's dressing supply bins into the closet and placed the garbage bag with old dressings/gloves, etc into a red hazardous waste bag. Finally, LPN-A washed her hands with soap and water and left the room with her treatment cart and waste bag. LPN-A took the hazardous waste bag directly to the soiled utility room and washed her hands with soap and water once disposing of the waste bag.

When interviewed on 1/18/14 at 11:20 a.m., LPN-A confirmed that she had not cleansed her hands between each glove change and stated, "I usually do". LPN-A further stated that she tends to be in a hurry and not cleanse her hands between each dressing change, but will always change her gloves between wounds.

When interviewed on 1/9/14 at 12:59 p.m., the assistant director of nursing (ADON) confirmed the expectation had been to perform proper hand hygiene with a change of gloves.

When interviewed on 1/19/14 at 2:37 p.m., the director of nursing (DON) confirmed she would expect hand hygiene to be performed before donning and after removal of soiled gloves during a dressing change.

The policy and procedure titled, "Hand Washing" dated 3/2010 indicated that hand washing is required before and after changing a dressing, and after removing gloves.

Review of the facility's infection control

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21390	Continued From page 6 surveillance information logs revealed no tracking or trending of staff illness and/or infection was evident . The impact of staff illness/infection had not been tracked related to the impact on the facility's resident population. Interview with the director of nursing (DON) on 1/9/14 at 8:27 a.m. confirmed a mechanism had not been established within their infection control program to track and trend staff illness and/or infection. The DON stated that she logs all infections for the residents but doesn't track the employees infections. SUGGESTED METHOD OF CORRECTION: The facility administrator or designee could review and revise policies and procedures in relation to the facility's infection control program. The administrator or designee could provide education to all facility staff on infection control. The administrator or designee could do weekly/monthly audits for compliance. The director of nursing (DON) or designee could develop, review, and/or revise Infection Control program and ensure that resident and staff infections are monitored and analyzed. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	21390		