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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: BR5O

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00414

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245419**
2.STATE VENDOR OR MEDICAID NO.
(L2) **546242800**

3. NAME AND ADDRESS OF FACILITY
(L3) **TWIN VALLEY LIVING CENTER**
(L4) **208 OPPEGARD AVENUE NORTHWEST, PO BOX 480**
(L5) **TWIN VALLEY, MN** (L6) **56584**

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 07/30/2013 (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 **58** (L18)

13.Total Certified Beds **58** (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
	58			
(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. Effective July 3, 2013, the facility is certified for 58 skilled nursing facility beds.

17. SURVEYOR SIGNATURE Date :
Susanne Reuss, Unit Supervisor 07/31/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 12/20/2013 (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
02/01/1987
(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
Posted 1/8/14 Ml BR5O

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/31/2013
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5419 December 20, 2013

Ms. Shari Schreiner, Administrator
Twin Valley Living Center
208 Oppegard Avenue Northwest, PO Box 480
Twin Valley, Minnesota 56584

Dear Ms. Schreiner:

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 July 3, 2013, the above facility is certified for:

58 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 58 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
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900, St. Paul, MN 55164-0900
Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

July 31, 2013

Ms. Shari Schreiner, Administrator
Twin Valley Living Center
208 Oppegard Avenue Northwest, PO Box 480
Twin Valley, Minnesota 56584

RE: Project Number S5337022

Dear Ms. Schreiner:

On June 21, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 13, 2013. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On July 30, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on July 19, 2013 the Minnesota Department of Public Safety completed a PCR by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 13, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 3, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 13, 2013, effective July 3, 2013 and therefore remedies outlined in our letter to you dated June 21, 2013, 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,

Colleen Leach

Colleen Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring

Enclosure
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245419	A. Building B. Wing	7/30/2013

Name of Facility	Street Address, City, State, Zip Code
TWIN VALLEY LIVING CENTER	208 OPPEGARD AVENUE NORTHWEST, PO BOX 480 TWIN VALLEY, MN 56584

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **07/03/2013**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **07/03/2013**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **07/03/2013**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **07/03/2013**	ID Prefix **F0492** Reg. # **483.75(b)** LSC	Correction Completed **07/03/2013**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	SR/cbl	07/31/2013	16022	07/30/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 6/13/2013

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	(Y3) Date of Revisit
245419	A. Building B. Wing 01 - MAIN BUILDING 01	7/19/2013

Name of Facility	Street Address, City, State, Zip Code
TWIN VALLEY LIVING CENTER	208 OPPEGARD AVENUE NORTHWEST, PO BOX 480 TWIN VALLEY, MN 56584

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 K0050	07/03/2013	ID Prefix Reg. # NFPA 101 LSC K0066	07/03/2013	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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/cbl	07/31/2013	12424	07/30/2013
CMS RO				

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
6/11/2013	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: BR5O

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00414

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245419**

2.STATE VENDOR OR MEDICAID NO.
(L2) **546242800**

3. NAME AND ADDRESS OF FACILITY
(L3) **TWIN VALLEY LIVING CENTER**
(L4) **208 OPPEGARD AVENUE NORTHWEST, PO BOX 480**
(L5) **TWIN VALLEY, MN** (L6) **56584**

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 **06/13/2013** (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 **58** (L18)

13.Total Certified Beds **58** (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
	58			
(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 :
Lyla Burkman, HFE-NEII 07/08/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Nicole Steege, Program Specialist 0730/2013 (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
02/01/1987
(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
Posted 7/31/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Page 2
Provider Number: 24-5419
Item 16 Continuation for CMS-1539

At the time of the standard survey completed on June 13, 2013, the facility was not in substantial compliance and the most serious deficiencies were a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed.

See attached CMS-2567 for survey results. Post Certification Revisit after July 3, 2013.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7012 3050 0000 4830 8151

June 21, 2013

Ms. Shari Schreiner, Administrator
Twin Valley Living Center
208 Oppegard Avenue Northwest, PO Box 480
Twin Valley, Minnesota 56584

RE: Project Number S5419023

Dear Ms. Schreiner:

On June 13, 2013, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), 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:

Suzanne Reuss
Minnesota Department of Health
P.O. BOX 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3793

Fax: (651) 201-3790

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

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 July 23, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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 September 13, 2013 (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 December 13, 2013 (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.

Feel free to contact me if you have questions.

Sincerely,

Suzanne Reuss, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3793 Fax: (651) 201-3790

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
	245419	A. BUILDING _____ B. WING _____	06/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN VALLEY LIVING CENTER	208 OPPEGARD AVENUE NORTHWEST, PO BOX 480 TWIN VALLEY, MN 56584

(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 ONSITE 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	F329: Nursing The Twin Valley Living Center must ensure that each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on interview and document review, the facility failed to monitor and identify that a blood pressure medication was frequently not being given, based on parameters, in order for the physician to determine if the medication dose needed to be adjusted due to low blood pressure/pulse readings for 1 of 10 residents (R41) whose medication regimens were reviewed.	All Completion dates 7/3/13 SER. ML
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 329	7/8/13 SER	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shaw Schreiner — TITLE: Executive Director — (X6) DATE: 7/3/13

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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	245419	A. BUILDING _____ B. WING _____	06/13/2013

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F 329	Continued From page 1 drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to monitor and identify that a blood pressure (BP) medication was frequently not being given, based on parameters, in order for the physician to determine if the medication dose needed to be adjusted due to low BP/pulse readings for 1 of 10 residents (R41) whose medication regimens were reviewed. Findings included: R41's diagnosis included hypertension. The physician order dated 2/1/13, indicated metoprolol tartrate (blood pressure medication) 50 mg to be administered twice a day. The order directed staff to hold the medication when R41's systolic blood pressure was less than 110 or pulse less than 60. R41's plan of care (POC) review date 3/28/13, identified the problem of hypertension. The interventions directed staff to monitor R41's blood pressure and pulse twice a day and as needed. Also to administer medications as ordered; observe for side effects of the medications (metoprolol); be aware that there were hold parameters on this medication; to hold the medication as ordered and notify the physician as needed. A review of R41's nursing documentation from 3/18/13 through 6/10/13, and medication administration record (MAR) from 4/1/13 through 6/10/13, identified 55 times when metoprolol had	F 329	On 6/12/13 the RN informed the nurse practitioner of the frequency of the metoprolol being held for R41 and the order was changed to metoprolol 25mg twice a day. The LPN's were educated regarding the need to monitor incidents of blood pressure medications that were held and to document such events in the computer under "Circulatory" or "Medications held" which will enable RN's to pull documentation from the computer charting. This documentation will then be addressed with the MD weekly when he/she is in house. In addition, staff will maintain the past 2 months of Medication Administration Records in each resident's active chart for ease in review of medications administered for each resident which would also include medications held. Random audits will be conducted weekly and brought to the Quality Assurance team for review until compliance is met. Staff will be counseled as needed regarding review of medications that were held and notifying the MD of medications held.	

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F 329	Continued From page 2 been held due to the blood pressure being below 110 or the pulse below 60. On 6/12/13, at 7:59 a.m. registered nurse (RN)-A stated the physician is provided a list of vital signs and recent nursing notes at the time physician rounds are made. On 6/12/13, at 8:27 a.m. RN-A stated she had informed the nurse practitioner of the frequency of the metoprolol being held for R41 and the order was changed to metoprolol 25 mg twice a day. On 6/12/13, at 12:43 p.m. director of nursing (DON) confirmed she was unaware of the frequency the metoprolol was being held for R41.	F 329	Director of Nursing or designee will monitor for compliance. 07/01/2013	7/3/13
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the licensed pharmacist reviewed and reported the trend of holding a blood pressure medication to the attending physician and director of nursing for 1 of 10 residents (R41) whose drug regimen was reviewed.	F 428	The Twin Valley Living Center must ensure the drug regimen of each resident must be reviewed at last once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. Based on interview and document review, the facility failed to ensure the licensed pharmacist reviewed and reported the trend of holding a blood pressure medication to the attending physician and director of nursing for 1 of 10 residents (R41) whose drug regimen was reviewed.	

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F 428	Continued From page 3 Findings included: R41's diagnosis included hypertension. The physician order dated 2/1/13, indicated metoprolol tartrate (blood pressure medication) 50 mg to be administered twice a day. The order directed staff to hold the medication when R41's systolic blood pressure was less than 110 or pulse less than 60. A review of R41's nursing documentation from 3/18/13 through 6/10/13, and medication administration record (MAR) from 4/1/13 through 6/10/13, identified 55 times when metoprolol had been held due to the blood pressure being below 110 or the pulse below 60. The monthly Pharmacist's Drug Regime Review for February through May 2013, lacked documentation for review of the metoprolol. On 6/12/13, at 8:27 a.m. registered nurse-A stated she had informed the nurse practitioner of the frequency of the metoprolol being held for R41 and the order was changed to metoprolol 25 mg twice a day. On 6/12/13, at 12:43 p.m. director of nursing confirmed she was unaware of the frequency in which the metoprolol had been held for R41. On 6/13/13, at 8:26 a.m. consulting pharmacist-A confirmed the monthly pharmacy medication review should include a review of medications which are being held. On 6/13/13, at 8:47 a.m. consulting pharmacist-B confirmed the monthly pharmacy medication review should include a review of medications which are being held and was unaware of the frequency in which the metoprolol had been held for R41.	F 428	On 6/12/13 the RN informed the nurse practitioner of the frequency of the metoprolol being held for R41 and the order was changed to metoprolol 25mg twice a day. The consulting pharmacist was educated regarding nursing staff will maintain the past 2 months Medication Administration Records in each resident's active chart which will allow for the consulting pharmacist to more easily identify trends in medications held. The consultant pharmacist was also notified that all blood pressure medications held will be documented under "Circulatory" or "Medication held" in the computer for ease in record review. Random audits will be conducted monthly and brought to the Quality Assurance team for review until compliance is met. Director of Nursing or designee will monitor for compliance.	7/3/13
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		

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F 431	Continued From page 4 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, 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 interview and document review, the facility failed to establish a system that was	F 431	The Twin Valley Living Center 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. Based on interview and document review, the facility failed to establish a system that was consistent with current standards of practice for the disposal of controlled substances within the facility, for 3 of 3 residents (R18, R8, R4) receiving a Fentanyl patch. In addition, the facility failed to ensure that a single unit dose eye drop was disposed of after use which affected 1 of 1 resident (R78) reviewed during the medication pass.	7/3/13

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F 431	Continued From page 5 consistent with current standards of practice for the disposal of controlled substances within the facility, for 3 of 3 residents (R18, R8, R4) receiving a Fentanyl patch. In addition, the facility failed to ensure that a single unit dose eye drop was disposed of after use which affected 1 of 1 resident (R78) reviewed during the medication pass. Findings include: During the medication administration observation on 6/12/13, at 9:05 a.m. the licensed practical nurse (LPN)-C removed two Fentanyl transdermal patches, Fentanyl transdermal patch 75 mcg and Fentanyl transdermal patch 25 mcg, from R18's back. LPN-C was observed to fold the patches together and then place them in the toilet and flush them into the sewer system. R18 diagnoses included peripheral neuropathy and pain. The current physician's order dated 4/15/13, included Fentanyl transdermal patches (narcotic, medicated patches used to relieve pain) 75 micrograms (mcg) per hour, to be changed every 72 hours. R8 diagnoses include hypertension and pain. The current physician's order dated 5/21/13 included Fentanyl 50mcg/hr (topical) change patch to be changed every 3 days R4 diagnoses include osteoarthritis. The current physician's order dated 5/12/13 included Fentanyl 50mcg/hr to be changed every 72 hours. On 6/12/13, at 12:02 p.m. during review of the locked unit medication cart, licensed practical nurse (LPN) - D stated after Fentanyl patches were removed from the resident, they are	F 431	The Twin Valley Living Center will ensure that all Fentanyl patches will be monitored each shift for placement and the destruction of Fentanyl patches will be witnessed and co-signed by 2 licensed staff members. In addition, the Twin Valley Living Center will ensure that all single unit dose eye drops will be discarded after the administration of each dose. The Medication Administration Record for residents R18, R8 and R4 were modified on 6/13/13 to include an area to document the site of the Fentanyl patch placement during administration and to document that staff is monitoring placement of the Fentanyl patch every shift. The licensed staff was educated on the policies regarding "Administration of Unit Dose Eye Drops" and "Monitoring and Destruction of Fentanyl Patches". Random audits will be conducted weekly and brought to the Quality Assurance team for review until compliance is met. Staff will be counseled as needed regarding administration of unit dose eye drops and monitoring and destruction of Fentanyl patches as needed.	

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F 431	Continued From page 6 disposed of by one nurse, via sewer. On 6/12/13, at 1:32 p.m. during review of the north medication cart with LPN-C. LPN-C stated the removal and disposal of Fentanyl patches is via sewer by one nurse. LPN-C stated currently 3 residents were prescribed Fentanyl patches, (R18, R8, R4). On 6/12/13, at 12:29 p.m. the main medication storage room was reviewed with registered nurse (RN)-B. RN-B stated Fentanyl patches are disposed of by one nurse by flushing down the sewer or deposited in a sharps container. On 6/12/13, at 12:48 p.m., RN-C stated during review of the east and south wing medication cart, when a Fentanyl patch is removed from a resident, it is flushed down the toilet by the nurse. On 6/12/13, at 1:05 p.m., the director of nursing (DON) stated one nurse disposes of Fentanyl patches; and stated the facility does not have a policy regarding Fentanyl patch disposal. R78 s diagnoses included dry eye syndrome. The Physicians Order dated 6/5/13, directed staff to administer Restasis (lubricating eye drop) 0.05% 1 drop to both eyes twice daily. On 6/10/13, at 7:25 p.m. during medication administration observations LPN-C was observed to administer Restasis one drop to both eyes to R78 via a single unit dose vial. When administration was complete LPN -C placed a cover on the single use unit vial and retuned the vial into the top drawer of the medication cart LPN -C stated that the single use vials were kept in the top of the cart until the resident was to receive another dose at a later date. On 6/12/13, at 12:48 p.m. the west medication cart was reviewed with RN-C. In the top drawer of the cart a clear soufflé cup with R78 s name was observed with an opened Restasis unit dose vial	F 431	Director of Nursing or designee will monitor for compliance. 07/01/2013 Tammy Courtright Director of Nursing	

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F 431	Continued From page 7 in it. A second Restasis single use unit dose was also in the same section, with no name or dates on the single unit dose identifying who it was for or when it was opened. RN-C stated the drops belonged to R78 and there was more than one drop in the unit dose so they save the drops to give later. On 6/12/13, at 12:55 p.m. RN-B stated the Restasis single use unit vials are disposable and are to be used for single doses. RN-B stated staff should not be saving them for future use. The manufacture insert dated 2013, from the Allergan incorporated read: "advice patients that the emulsion from one individual single-use vial is to be used immediately after opening for administration to one or both eyes, and the remaining contents should be discarded immediately after administration." On 6/12/13 at 1:00 p.m. the DON stated she was unaware the Restasis had been dispensed in single unit vials or that staff were saving them for future use. She stated all single use medications were to be disposed after use.	F 431		
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 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,	F 441	The Twin Valley Living Center 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.	7/3/13

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F 441	Continued From page 8 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 document review, the facility staff failed to wash their hands after direct contact for 1 of 3 resident (R76) observations of personal care for which hand washing was indicated. Findings included: R76's diagnoses included perineal intertigo (inflammation of skin folds), cellulitis (skin infection) on his left leg and buttocks, urinary tract infection (UTI) with cabapenem resistant enterobacteriaceae (CRE) (antibiotic resistant	F 441	Based on observation, interview, and document review, the facility staff failed to wash their hands after direct contact for 1 of 3 resident (R76) observations of personal care for which hand washing was indicated. The staff member involved reported that she recognized her error and disinfected all services she had come in contact with while wearing her soiled gloves. The individual staff member was counseled on the importance of washing hands prior to cares, wearing gloves during cares when there is the potential to come in contact with body fluids, to remove soiled gloves and wash hands when cares are completed and to don a fresh set of gloves for any additional cares in which staff may come in contact with body fluids. Staff will receive yearly inservice training on handwashing techniques and infection control practices. Random audits will be conducted weekly to ensure that staff are washing hands and changing gloves when appropriate. These audits will be brought to the Quality Assurance team for review until compliance is met. Staff will be counseled as needed with regard to hand washing, use of gloves and good infection control practices.	

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F 441	Continued From page 9 infection). R76 had an indwelling catheter and was placed in contact isolation due to the diagnosis of CRE. R76's plan of care (POC) dated 6/4/13, indicated R76 required the assist of two for transferring and was to use the bedpan or commode for bowel movements. The POC directed staff to use good hand washing technique before and after all cares and to wear a gown and gloves when assisting R76 when they were likely to come in contact with urine, drainage, or bed linens. On 6/12/13, at 9:12 a.m. nursing assistant (NA)-A and NA-B entered R76's room wearing isolation gowns. Both NA's went into the resident's bathroom and washed their hands and donned gloves. NA-A collected a packet of disposable wipes, removed the covers from R76 and positioned him on his back. NA-A completed catheter care and continued with cares without removing gloves or washing hands. NA-A assisted R76 to his right side where he was found to have a moderate amount of dried, smeared bowel movement (BM) on both buttocks. NA-A proceeded to utilize the disposable wipes to clean the BM by wiping his bottom four times and placed the wipes in the nearby garbage can. NA-A used her gloved hands to spread R76's buttocks to assure she had removed all of the BM. NA-A continued to be observed during cares to touch with soiled gloves the catheter bag and tubing, the resident's clothing, wheelchair, gait belt, bathroom door, dresser drawers, bedside stand, deodorant can, and the resident's body. During this time NA-A was observed to have not removed her soiled gloves or wash her hands. On 6/12/13, at 9:32 a.m. NA-A stated she should have removed her gloves and washed her hands after completing perineal care and assisting R76	F 441	Director of Nursing or designee will monitor for compliance. 07/01/2013	

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F 441	Continued From page 10 with cares. Review of the facility's undated Contact Precautions policy directed staff to wear gloves whenever touching the resident's skin or surfaces in close proximity to the resident, to change gloves between tasks and to wash hands after removing gloves. Review of the facility's Body Substance Isolation Procedure revised date 3/13/96, requires staff to wear gloves when coming in contact with BM and to wash hands after contact. On 6/12/13, at 12:43 p.m. director of nursing (DON) confirmed the facility's policy and procedure for when staff are completing perineal care, they should wash their hands prior to cares, wear gloves during cares, remove the soiled gloves directly after coming in contact with BM and wash their hands.	F 441		
F 492 SS=D	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to submit a resident request for a demand bill and/or failed to stop charging for services when a demand bill had been submitted for 2 of 3 residents (R56, R29) demand bills reviewed.	F 492		

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	245419	A. BUILDING _____ B. WING _____	06/13/2013

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TWIN VALLEY LIVING CENTER	208 OPPEGARD AVENUE NORTHWEST, PO BOX 480 TWIN VALLEY, MN 56584

(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 492	Continued From page 11 Findings include R56's family received a Notice of Medicare Non-Coverage on 1/18/13, which indicated the effective date of coverage of skilled therapy services would end on 1/21/13. The form indicated R56's family member signed the form on 1/18/13, and requested to have this decision appealed. However this appeal was not submitted to the Fiscal Intermediary or Medical Administrative for review. On 6/11/13, at 2:25 p.m. the business office manager stated this appeal notice had been overlooked and "it just got missed." She stated the resident was privat pay and the family was billed. R29 had received a Notice of Medicare Non-Coverage on 3/23/13, which indicated the effective date of coverage of skilled therapy would end on 3/25/13. The form indicted R56 signed the form on 3/23/13, and requested to have this decision appealed. On 6/11/13, at 2:30 p.m. the business office manager stated the appeal decision was still pending and the facility was billing Medicaid for R29's services. The office manager stated she was aware she could not bill for private pay resident's until the decision was finalized but understood she could bill Medicaid while the request was being reviewed. The facility did not provide a policy related to the liability notice or demand bill.	F 492	Twin Valley Living Center must operate and provide services in compliance with all applicable regulation and laws. The facility failed to submit a resident request for a demand bill and/or failed to stop charging for services when a demand bill had been submitted for 2 or 3 residents. An office meeting was held on 6/18/2013 regarding deficiencies. Billing manager will keep spreadsheet of demand bills given to her by RN staff. The demand bill will be submitted electronically during the regular billing cycle. There will be no other billing submitted until notice is received from fiscal intermediary regarding determination. Demand billing for resident #56 was submitted 7/2/2013. Demand bill determination for resident #29 #56 was retuned on 6/24/2013 then Medicaid billing was sent on 7/1/2013. See Policy on demand billing (attachment B) for Twin Valley Living Center. Administrator of her designee will monitor for compliance. 7/3/2013	7/3/13

Monitoring and Destruction of Fentanyl (Duragesic) Patches

Staff will monitor placement of resident's Fentanyl (Duragesic) patch every shift to ensure that patch continues in place as directed. This will be documented on the Medication Administration Record.

In the event that the patch is missing staff will investigate to try to find the patch (Ex: fell off, etc.). If the patch is not found it is to be reported to the RN Supervisor or Director of Nursing for further investigation.

Upon removal of a Fentanyl (Duragesic) patch the patch is to be folded sticky side in and flushed into the sewer system. This destruction will be witnessed by 2 licensed staff and signed out in the narcotic log book.

The new Fentanyl (Duragesic) patch will then be signed out and applied as directed. The nurse will document placement site for ease in monitoring of placement.

Adopted by the Quality Assurance Committee: 7/3/13

Administration of Unit Dose Eye Drops

1. Wash hands.
2. Check medication label and order.
3. (For 'Restasis') Invert unit dose vial a few times to obtain a uniform, white emulsion.
4. Put on non-sterile gloves.
5. Remove tip from vial.
6. Have resident tip head back slightly if able.
7. With dominate hand, hold vial above the eye, stabilizing hand on forehead.
8. With non-dominate hand, gently pull cheek down to expose lower conjunctival sac.
9. Have the resident look upward.

Squeeze the vial to administer the ordered amount of medication, making sure not to touch the eye or lashes with the vial.

10. Instruct the resident to close and move eyes gently - do not squeeze eyelids. Offer tissue to wipe any drips - do not rub the eye.
11. Administer drop(s) to the other eye with same procedure if ordered.
12. Dispose of unit dose vial in garbage. Do not reuse or save vial.
13. Remove gloves and wash hands.

Adopted by the Quality Assurance Committee: 4/3/13

Attachment B

Demand Billing Policy

For residents receiving a level of care denial (Medicare Services are no longer necessary) the notice must include an opportunity for the resident to request the facility submit a demand bill to Medicare for review.

For residents who did request the submission of a demand bill through Medicare, the facility must not charge the beneficiary/legal representative for covered services while the demand bill is under review by Medicare.

Adopted 7/2/2013

Attending Physician: Dr Patrick Luger -Meritcare Clinic (Desk #35) -737 Broadway -Fargo, ND 58123 Phone: 1-800

Orders	Hours	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
DURAGESIC (fentan) 25mcg/hr PATCH Change q 72 hours (Osteoarthritis) 10am Site	**10am**																															
	Site																															
Monitor Duragesic patch placement every shift. N D R	**N**																															
	D																															
	R																															

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

F5419022

PRINTED: 06/21/2013
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
	245419	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/11/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN VALLEY LIVING CENTER	**208 OPPEGARD AVENUE NORTHWEST, PO BOX 480 TWIN VALLEY, MN 56584**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Twin Valley Living Center 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by email to:	K 000	 POC ok FS 7-8-13	

DC: 07.23.2013
Exit: 6.13.2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shari Schmeiser, TITLE: Executive Director (X6) DATE: 7/3/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Barbara.Lundberg@state.mn.us Fax Number 651-215-0525 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 Twin Valley Living Center is a 1-story building without a basement. The building was constructed at six different times. The original building was constructed in 1965 and was determined to be of Type II(111) construction. In 1969, a dining room addition was constructed to the south of the building that was determined to be of Type II(000) construction. In 1975 additions to the dining room and a activates were constructed and was determined to be Type II (000) constitution. In 1981, a sleeping room addition was constructed on the east side of the facility that was determined to be of Type V(111) construction. In 1992, a dayroom was added to the north of the 1965 building that is of Type II(111) construction. In 1995, a small dining room addition was added to the east side of the north wing of the 1965 building that is of Type II(111) construction. The latest addition was an administration wing in 1996 to the south of the	K 000		

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K 000	Continued From page 2 1981 addition, which is of Type V(111) construction. The building is divided into 9 smoke zones. The building is fully sprinklered throughout in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition . The facility has a fire alarm system with smoke detection at smoke barrier doors and in spaces open to the corridors that is monitored for automatic fire department notification in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition with single station smoke detection in all resident sleeping rooms Other hazardous areas have automatic fire detection that is on the fire alarm system in accordance with the Minnesota State Fire Code 2007 edition. The facility has a capacity of 58 beds and had a census of 55 at the time of the survey. Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as a single building. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are	K 050		

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K 050	Continued From page 3 conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: A review of fire drill records revealed that the facility staff have not conducted fire exit drills in accordance with National Fire Protection Association (NFPA) 101 "The Life Safety Code" (LSC) 2000 edition section 19.7.1.2. Not conducting fire exit drills could allow confusion and delay in the staff response, which would negatively impact all residents, visitors and staff in a fire emergency. Findings include: A review of the fire exit drill records for Twin Valley Living Center for 2012 and 2013, prior to the facility tour on June 11, 2013 at approximately 9:30 am, by surveyor 03006 revealed that the fire exit drills have not been conducted at unexpected times under varying conditions. 1) The four evening drills have all been conducted between 3:00 pm and 3:45 pm, and 2 Three overnight drills have been conducted between 6:10 am and 6:35 am. The Director of Maintenance and the Administrator verified these findings during the facility tour and during the exit conference.	K 050	Twin Valley Living Center must ensure fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. Fire drills were conducted on a routine basis with the evening shift hours varying from 3:00 through 3:45 pm, and the night shift between 6:10 through 6:35. Twin Valley Living Center will conduct fire drills at varying times in accordance with the Life Safety Code 2000 edition section 19.7.1.2. These drills will be completed and monitored by the Maintenance Director or his designee. 7/3/2013	7/3/13
K 066 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or	K 066		

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K 066	Continued From page 4 compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: A review of records and a staff interview, the facility's written smoking policy is not in accordance with National Fire Protection Association (NFPA) 101 "The Life Safety Code" (LSC) 2000 edition, Section 19.7.4. This deficient practice could negatively affect all residents, visitors, and staff if a fire occurs. Findings include: A review of the smoking policy for Twin Valley Living Center and an interview with the Administrator, prior to the facility tour on June 11, 2013 at approximately 9:40 am, by surveyor 03006 revealed that the smoke policy has not	K 066	Twin Valley Living Center must ensure Smoking Policy is followed to ensure all resident, visitor, and staff safety. Currently there are no residents who smoke in the facility. The policy was updated to reflect no smoking in building or grounds. Monitoring will be completed by Administrator or her designee. Attachment C 7/3/2013	7/3/13

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K 066	Continued From page 5 been completely updated and states the facility is no smoking. An interview with the administrator indicated that residents are allowed to smoke outside of the facility. No information on how staff determine which residents are capable of smoking and the control of smoking materials by staff was available. The Director of Maintenance and the Administrator verified these findings during the facility tour and during the exit conference.	K 066		

Attachment C

Twin Valley Living Center
No Smoking Policy

To ensure resident, family, visitor, and staff safety Twin Valley Living Center is a nonsmoking facility and grounds. This information will be given to potential residents and given as part of the admission packet.

Adopted 7/3/2013

Lutheran Homes
A mission of caring for over 50 years

www.LutheranLivingCenters.com

7/3/2013

Health Care Fire Inspection
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, MN 55101

To whom it may concern,

Enclosed you will find the plan of correction for Twin Valley Living Center with attachments. If you have any questions please feel free to contact me, 218-584-5181.

Sincerely,

Shari Schreiner

Shari Schreiner, Executive Director
Twin Valley Living Center

Twin Valley Locations
- Corporate Office
- Twin Valley Living Center
- Lincoln Terrace (Housing with Services)
- The Normandy
  (Independent Living with Support Services)
- Valley Pines (Senior Subsidized Housing)

PO Box 480 - 208 Oppegard Ave. NW
Twin Valley, MN 56584-0480
218-584-5181 – Fax 218-584-5304

Halstad Locations
- Halstad Living Center
- Heritage House
  (Independent Living with Support Services)

133 4th Ave. East
Halstad, MN 56548-9503
218-456-2105
Fax 218-456-2290